



CANADIAN HOSPITAL

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Obiter Dicta

Manitoba and Saskatchewan Plan Full-time Secretariats

THE unanimous decision of the Manitoba Hospital Association to engage a full-time secretary is indicative of the determination of that body to serve its members to the fullest possible extent. Under the part-time secretaryship of Ernest Gagnon, the association has made tremendous progress and has made many noteworthy contributions to the health and social welfare of the province. The association and the hospitals and patients which it serves are deeply indebted to a Secretary who has worked so indefatigably on their behalf. But the task has become too great for one whose other duties require all his time and thought, and who can only do this extra work at the expense of his rest and personal interests.

It is significant that Saskatchewan came to the same conclusion a few days earlier. This association has borne a heavy responsibility during the changing period of hospital finance under the provincial hospitalization scheme in the past two years. Here, too, the Secretary, John Smith of Yorkton, has had to devote his leisure hours to association work. As in the case of Manitoba, the other officers, although burdened down with their own tasks, have shared the work.

The ever-present problem, of course, is that of finance. The Saskatchewan association is being helped by the action of the government in permitting the extra assessments on the hospitals to be recognized as legitimate operating charges. This action by Mr. Douglas and Dr. Mott is much appreciated. In the case of Manitoba, the financing of the undertaking presents a more difficult matter. It is planned that the full-time secretary will

include among his duties that of consultant on accounting to the member hospitals, a type of service now available in several other associations. To make the plan feasible, it will be necessary for a sufficient number of the hospitals to agree to a special assessment for this consulting service. Judging by the experience in other provinces the value of such a consulting service should far outweigh the cost to the hospital, not to mention the many other advantages of having a secretary whose whole time, apart from this activity, is available for association work.



Should the Cost of Diagnosis Be Included in Hospital Costs?

ON every hand we hear individuals bemoaning rising hospital costs and indulging in nostalgic reference to the "good old days" when basic ward rates were two or three dollars per day. Let us not forget that in the "good old days" the patient received food, shelter, nursing, and little more. Hospital care was regarded as including treatment services only. Today diagnostic services constitute from thirty to eighty per cent of the patient's bill. One might contend with reason that diagnosis is the function of the physician and that diagnostic services should be shown on a separate account and not included in the hospital bill as hospital services.

In the past ten years myelography has come into general use. A myelographic series requires from eight to twelve films and from a half to one hour of a radiologist's time.

A gastric series may require five or six films and from one to one and a half hours of the radiologist's time. Bronchograms are time-consuming and expensive.

Electro-encephalography was almost unknown ten years ago. Now many hospitals provide this service. The taking and completing of two electro-encephalograms constitutes a full day's work.

In biochemistry, a serum phosphatase test requires six working hours of the time of one technician. Enzyme tests such as the amylase and lipase tests require about five hours.

In the metabolic laboratory we find tests that are even more time-consuming and costly. The pregnantdiol test requires about eight actual working hours. The follicle stimulating hormone test requires ten hours. These tests run through a week and if only two or three tests are being run these two or three may take the time of one employee for one week.

The technicians required in the work referred to are usually university graduates and must receive salaries commensurate with their training.

"Are these services worth-while or are they merely scientific frills?" someone asks. The answer involves both practical and humanitarian considerations. To us it seems worth-while to discover a protruding disc and to rehabilitate a suffering individual to a life of comfortable usefulness. It seems worth-while to discover the cause of a woman's sterility and enable her to become a happy mother.

Of course these and many other diagnostic services cost money, and they contribute to the so-called rising cost of hospitalization. While we are on the subject of costs, don't forget that the buying power of the Canadian dollar is about one-half of what it was in the "good old days", and that most people are earning at least twice as many dollars as they did in the hungry thirties.

Should not diagnostic services be billed for as such, and not as hospital services?—A.C.McG.



Television in Medicine

DURING the past few years ample evidence has been given on this continent of the efficacy of television as a teaching medium in medicine. Two years ago the American College of Surgeons used it for the first time on this continent when groups of surgeons sitting comfortably in the Waldorf-Astoria looked deep into an incision during an operation going on in a hospital many blocks away. The American Medical Association had a demonstration at the Chicago convention the next year and last spring the Canadian Medical Association enjoyed a successful demonstration at Saskatoon. At Sunnybrook this fall the Ambulatory Fracture Association, meeting in the auditorium, watched an operation going on 150 yards away. Famous Players Inc. lent the equipment and RCA Victor supplied the multiple screens.

This fall the American College of Surgeons meeting in Chicago conducted television demonstrations all through the week—this time in colour. Delegates were most

enthusiastic, for the colour seemed to add considerably to the depth of the field and, of course, lent a normal appearance to the operative field. For the first time hospital procedures, too, were televised, the projection being from St. Luke's Hospital to the Stevens Hotel.

That this method of teaching has a future is obvious. It is particularly adaptable to cavity surgery for the televising "eye" close to the surgeon's head provided a close-up view usually shared only by the first assistant and far better than any view available to onlookers on the stands or on the floor. Already a permanent installation has been made at Guy's Hospital in London. (See *Hospital and Health Management*, June, 1949; and *The Canadian Hospital*, October, 1949). The major problem will probably be that of finance, for installations are costly and may well remain so, and maintenance will require the services of technical experts.



Are You Risking Cirrhosis of the Liver?

IF the Banting Institute in Toronto isn't careful, it will be getting in the black books of the soft drink manufacturers, some of whom have made unusually large fortunes from their products. Research workers at this great laboratory which is under the direction of Prof. Charles H. Best, have found that cirrhosis or hardening of the liver may be caused not only by too much alcohol but by a deficiency condition due to the ingestion of too much sugar. It has been noted that this may be associated with the excessive use of soft drinks. The diet of an alcoholic or a soft-drink addict is not normal, it is stated, and the result is a shortage of choline, which here acts as a protective substance to the liver. The increased caloric content resulting from the ingestion of alcohol or soft drinks increases the need for choline to protect the liver from fatty changes which might lead to cirrhosis.

The association of hepatic cirrhosis with excessive sugar intake has long been known although the press gave the impression that this was a new idea. In our undergraduate days the best available specimen of alcoholic cirrhosis of the liver was from a stout woman who had been a teetotaler and an ardent temperance advocate. This embarrassing discovery at the autopsy did not indicate any insincerity or double life on her part, but was considered to be due to an excessive intake of sugar, in her case evidenced by an insatiable hunger for boxed candy.

Hitherto most of the criticism of certain more popular soft drinks has been because of their stimulating qualities arising from a fairly high content of caffeine-type alkaloids. As many young people take quite a number of bottles in a day, often at the expense of other nourishment, not to mention a fairly common evening practice of reinforcing the concoction with still more stimulating beverages, the effect on the nerves of the nation in an already too-jittery world is far from soothing. We would be more concerned about this over-stimulation than about liver damage from the sugar content despite its experimental production at the Banting, for not many people apart from alcoholics would seem to have developed cirrhosis of the liver.

Medical Education and Hospitals

GOVERNING bodies and staffs of hospitals and universities with medical faculties are anxious about their ability to finance extended facilities, and especially the training of personnel required to operate those facilities.

Hospitals need medical schools, for hospitals could not be operated if well qualified practitioners were not periodically graduated. The future and the fate of medical schools is your concern.

Costs

In 1940, at the University of Toronto the yearly per capita cost of training a medical student in his professional course was about \$800. Today, that yearly per capita cost is \$1,300 and, if we include the cost to the University of medical research projects which are essentially complementary to medical education, the figure would be in the neighbourhood of \$1,600 per student per annum. Tuition fees have been increased from \$300 to \$450 during that period.

Increasing expenditures for medical education are not peculiar to the University of Toronto. In a survey recently conducted, it was estimated that the cost of medical education in the Canadian medical schools is in excess of \$1,600 a year per student, and that Canadian medical students pay in tuition fees about one quarter of that cost.

Comparable costs in the United States range from \$735 to a peak of \$9,500 in a leading medical school. In the University of London the per capita annual expenditure on medical students was, before the devaluation of the pound, \$1,108.

Medical schools, so essential to the welfare of Canada, are by far the most expensive among the faculties of any university. It is only through

From an address at the 25th anniversary banquet of the Ontario Hospital Association last month.

Sidney E. Smith, LL.D., D.C.L.,
President, University of Toronto,
Toronto, Ont.

devotion to their profession and anxiety to advance the health of the people that outstanding practitioners teach in medical schools for a yearly amount that cannot be even dignified by the designation of honorarium. If a university were to pay full-time salaries to most of its staff, the figures would be increased many fold.

The increases in tuition fees for medical students—fees which are now higher than those for any other course in our Canadian universities—are reflected in the changing composition of our entering classes. The economic factor is making it more difficult and in many cases impossible for the gifted boy from rural districts to take a medical course. More and more students in Canadian medical schools are coming from towns and cities near the universities.

Character and talent are, of course, to be found in the homes where financial resources make it possible for the children to take a long and expensive medical course; yet the schools, the profession, the hospitals, and Canada need the alert minds, the firm muscles and the capacity for hard work that are so frequently to be found in farm boys.

There is properly much discussion about the distribution of medical practitioners in Canada and the difficulty that the people of rural areas are finding in attracting young medical students to make their careers among them. It may be that more medical students from those districts would remedy this dire situation.

Our Canadian medical schools are truly national schools, for their graduates, irrespective of their places of origin, go forth to practise in all the provinces of Canada. The mobility of medical graduates is second to that of no other group. Moreover, their service is national in that health or disease in one district, however isolated, may affect directly the health or disease in other or all parts of Canada.

Research

The pursuit of medical research is complementary to medical education in that the investigators as instructors are vital and inspiring, giving from a source of knowledge and experience that is being constantly replenished.

To change my metaphor, one cannot teach well if one is merely a phonograph record of the findings of others. It is incumbent on the medical schools to train research workers, who in their turn will be qualified to push forward tomorrow the frontiers of knowledge.

It is easier to get from governmental agencies and individual donors funds for medical research than for any other educational purpose. The funds are needed, they are gratefully accepted, and they are prudently administered and used. Yet it is a fact that a grant of money for medical research adds approximately thirty per cent of the amount to the overhead costs of the medical schools; as for example, extra heat, light, power, caretaking and clerical help, additional physical facilities and increased depreciation.

All political parties represented in



the House of Commons have endorsed programs for the improvement of the health of the Canadian people. Along with the hospitals, the Canadian universities are anxious to contribute to those programs which will touch every family and every individual in Canada.

But those institutions will not be able to fulfil their responsibilities if greater financial support is not accorded to them. That is primarily, I submit, a national responsibility and we must look for greater assistance from the Dominion Government. If the hospitals and the medical schools are unable to keep pace with and to provide qualified personnel for the extending programs, the programs will fail.

Teaching Hospitals

Medical education is for you and for us of the universities a common cause. I stated earlier in my remarks that the hospitals need the medical schools. I now declare with equal emphasis that the medical schools need the hospitals. I seize this opportunity to pay a warm and indeed a glowing tribute to the teaching hospitals of this province.

They are performing essential tasks in medical education. Teaching a medical student in classrooms and laboratories within the university would be quite barren if it were not for the opportunity that the medical student has to apply principles, vali-

dated in theory, in the rooms and wards of a teaching hospital.

In no other professional school, unless it be that of dentistry, can there be afforded such opportunities to translate theory into wise practice. Instruction on wards and in clinics, and internships, are of the utmost importance in the development of competent physicians.

Under direct supervision of gifted preceptors, medical students are encouraged and enabled in the teaching hospitals to accept and to discharge graded responsibility for the care and treatment of patients and to develop those characteristics which are the *sine qua non* of successful practice—self-reliance and resourcefulness.

That is the contribution of teaching hospitals. I know full well the additional burden of administration and the extra burden of costs that are thrown on teaching hospitals by reason of their direct participation in medical education. Non-teaching hospitals should equally recognize the two-fold contributions of their sister-institutions which redound to the advantage of all.

General Practice

I spoke a few moments ago of self-reliance and resourcefulness in the medical graduate. As a layman, I have wondered — admittedly not knowing all the facts—whether clinical training in a large, well equipped, modern hospital with its modern la-

boratory services, its staff of expert specialists and highly qualified nurses, is always the best preparation for the young graduate who may practise in localities where those facilities and that assistance are not available. Moreover, one is prone to inquire whether the instruction in the hospital covers the range of practice known to that keystone of the medical art—the general practitioner.

It has been stated that only ten per cent of those who are ill seek admittance to a hospital. As a consequence, the medical student does not see at close hand ninety per cent of the scope of general practice. In these days of hospital congestion the medical student may see only emergency conditions and he does not see in the teaching hospital many minor ailments.

One may also ask if the medical student in these crowded days, has an opportunity to study carefully, behind the symptom and diagnosis, *the man*, the patient whose environment, domestic situation, and working conditions may be as important to the general practitioner as his pulse rate and thermometer reading.

The country practitioner of yesteryear carried in his black bag his drugs, thermometer, stethoscope and other instruments, but he also took to the darkened room an understanding of human nature engendered by his attitude that the patient was something more than an interesting, inanimate laboratory specimen, that he was animate and human.

Of necessity most cases in a hospital require treatment to mend or cure a condition. Does the medical student have an opportunity there to study at first hand the nature of the life process and to learn steps to promote in his patients, who appear to be well, full and positive health in their future years?

Country Practitioner as Teacher

Without consulting my medical colleagues, I raise the question whether during vacations or during the term, medical students could not be attached to carefully selected general practitioners, preferably outside large cities, and learn the problems of those areas which may be vastly different from the ones found in metropolitan hospitals. The young men could thereby appreciate and
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And They Huffed . . . And They Puffed . . .

At the birthday banquet of the Ontario Hospital Association last month, Dr. Agnew, Miss Priscilla Campbell, and Mr. A. J. Swanson, three who were present at the first convention, blew out the candles on the 25th Anniversary cake.

C.H.C. Secretary Resigns

A Message from the President

To the Provincial Hospital Associations, to the Catholic Hospital Conferences, and to all other organizations associated with Canadian Hospital Council activities:

EVERYONE associated with the hospital field will be grieved to learn that Dr. Harvey Agnew has submitted his resignation to the Executive Committee of the Canadian Hospital Council. Dr. Agnew himself was reluctant to take this step and his resignation was accepted with sincere and understanding regret. He values the friendship of his hospital associates and his heart was and always will be in the work of the Council.

Tempting offers have come to him during recent years, as was to be expected. His outstanding qualifications are known nationally and internationally. On previous occasions he has elected to stay with the Council because its interests were his own. It would have been the same this time had he not felt that the value of the Council has now been demonstrated and that it will continue its progress under new direction. He now feels that, after 18 years of his guidance, the organization has reached that maturity which permits him to think—at long last—of himself. With mixed feelings, regret at breaking his present ties, consciousness of a job well done, and enthusiasm for new and interesting work, he has decided to accept a favourable opening in a field that appeals to him strongly, hospital consulting.*

But Dr. Agnew would not leave without due regard for the interests

*Dr. Agnew is becoming a partner in the firm, Neergaard and Craig, Hospital Consulting Services, New York, which will henceforth be known as Neergaard, Agnew and Craig. The firm is opening a Toronto office which will be under the direction of Dr. Agnew.

of the hospitals. He has insisted, in negotiations with his new partners, that until July 1st he reserve half his time for the work of the Council. He has assisted the Council in the choice of an assistant secretary and will work closely with this new official. In addition, Dr. Agnew will help in all ways as his time is available. He will remain as Editor of the *Canadian Hospital Journal* until July, and it is hoped



Harvey Agnew, M.D.
Executive Secretary of the Canadian Hospital Council since its origin in 1931.

that he will continue on the Editorial Board.

Dr. Agnew will also continue on a part-time basis as director of the School of Hospital Administration, which he was instrumental in establishing at the University of Toronto two years ago.

It is fortunate for Canada that he will continue his residence in Toronto and that much of his work will be in and for this country.

It is natural that Council officers and members of the Executive view the situation with concern. Each and every one admits without hesitation that the strength of the Council has come largely from Dr. Agnew's strength. In the hospital

field he is the Canadian *MacEachern*, spreading goodwill and friendship, bringing hospital organizations together on a common ground, winning nation-wide respect for and confidence in the Council's work. Thousands of people consider him their intimate friend and appreciate his ability. His place will be hard to fill.

The members of the Executive fully realize this difficulty. Their concern is lessened, however, by several factors. First and foremost of these is that the Council's interest remains Dr. Agnew's interest. He has created a strong hospital organization and he desires that organization to maintain its present strength and to increase it. He brings, therefore, to all hospital authorities, to all hospitals, and to all hospital people, an actual challenge. We must not let him down. His expectant attitude gives your directors encouragement.

The second encouragement comes from the qualities of the new assistant secretary, Murray Ross of Edmonton, whose services the Council has been very fortunate in obtaining. He will undertake his new duties at the beginning of the coming year and further reference to his qualifications will be made in the January issue. The Executive appreciates the co-operation of the Chairman of the Board and the Superintendent of the Royal Alexandra Hospital, Edmonton, in releasing Murray Ross to the larger hospital field.

On behalf of the officers of the Council and all persons in the hospital field, I tender to Dr. Agnew sincere thanks for the grand work he has done during 21 years of hospital service and extend to him the best possible wishes for his future success and happiness.

R. FRASER ARMSTRONG,
President.

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Glancing Backward

In view of the President's announcement, the officers of the Council feel that it is appropriate to recall at this time one or two of the enduring contributions made by Dr. Agnew during his years of outstanding service to hospitals of this continent.

When in 1942 and 1943 it seemed

possible that a system of social security, including health insurance, would be implemented in Canada and the late Dr. J. J. Haegerty was drawing up his famous report, Dr. Agnew, with the late Dr. G. F. Stephens and others, worked assiduously to ensure that under any such system the voluntary hospital system would be preserved. With the assistance of a committee on health insurance, it was he who drew up the brief entitled "Principles of Health Insurance as they relate to Hospitals" which was submitted to the Dominion Government by the Canadian Hospital Council. That brief has been the basis for the government hospitalization schemes developed in two Canadian provinces, schemes under which hospitals have retained their cherished independence.

One other outstanding treatise which will always reflect credit upon its author was that on the

point rating system of evaluating hospital work. With suitable revisions that system, born of Dr. Agnew's resourceful mind, is being used in one of our provinces today and is also utilized by the American College of Surgeons in its annual surveys for approval purposes.

Let us go back over 20 years. When in 1928 Dr. Agnew undertook an advisory service to the hospitals of Canada, under the Canadian Medical Association, there was not available for use any overall listing of the hospitals in Canada. He promptly started to prepare one. At his instigation and with the assistance of Dr. Helen MacMurchy, the Dominion Government, through its then Department of Pensions and National Health, was prevailed upon to publish the first directory of Canadian hospitals. Copies of that original issue, compiled and illustrated by Dr. Agnew, are preserved

as items of *Canadiana* in our public libraries and have been sought by libraries abroad. This, his first contribution to hospital literature, is mentioned here because it illustrates the strong personal qualities, including initiative and persuasiveness, which Dr. Agnew has brought to each project undertaken in his years of service to the field.

Since 1935 he has been editor of our journal, through the pages of which he has interpreted Council policy with integrity and brilliance. His facile pen has ever been poised to challenge any movement which might be harmful to our hospitals; and readers have been charmed again and again by the inherent artistry of his pencil in those thumbnail sketches which have for so long brightened these columns. Readers will be grateful for the assurance that he will continue to make contributions to *The Canadian Hospital*.

Essential Considerations in Rural Hospital Development

The Chairman of the Manitoba Health Services Commission would (1) hold up further construction until a supply of nurses can be assured; (2) insist that future construction conform to the overall pattern laid down for the province, rather than depart from it because of local pressure; and (3) confine certain diagnostic equipment to strategically-located hospitals which could be assured of enough patronage to warrant the outlay required for equipment and staff.

IN view of the fact that many articles on this subject have appeared recently in the press, and also in view of the fact that the Minister has, by his statement in the press, seen fit to place upon the shoulders of the Manitoba Hospital Council and the Manitoba Health Advisory Commission, the responsibility for present-day conditions in the hospital field by their approval of all schemes now in effect and to be

An address at the convention of the Manitoba Hospital Association, Winnipeg, in October.

Judge J. Milton George,
Chairman,
Manitoba Health Services Commission,
Morden, Man.

put into effect, it leaves me no alternative but to deal frankly with the subject by stating the facts, and placing before you the conditions under which approval of these two advisory bodies were sought. Remember that these two bodies are only advisory, with no jurisdiction over administration.

Following my remarks last year,

Dr. Harvey Agnew made this very significant statement, along with other equally pertinent opinions, "I would think that associations like this have some responsibility to acquaint the people with the facts, through the press, or by meetings, or through other means." Meetings such as this are one of the best opportunities we have of passing on such knowledge as we possess, and we would be failing in our duty if we failed to take advantage of them.

Last year I asked this question, "Are we in danger of building too many hospital beds?" and followed it up with this statement, "The problem is not one of building too many beds but of wrong distribution of hospital beds throughout the province. The care that we must take is to place the hospital beds where they are needed most . . . to build up the most efficient system that we can."

We have not followed out that policy. In the rapid development of hospitals we have lost sight of it.

We are now faced with the greatest problem of all, namely, a serious shortage of nurses to man our pres-

ent hospitals and those under construction. This makes it necessary to deal almost exclusively with the nursing situation; to do so effectively, I must give you a history of what steps have been taken to deal with this problem.

On February 18, 1947, the writer submitted to the Health Advisory Commission a brief setting forth his views on the development of the scheme outlined in the Health Services Act, emphasizing the problems he thought we might run up against. This was approved by the Commission and a copy furnished to the Minister of Health. To quote one statement:

"Every hospital in the province is running short-handed on its nursing staff; four hospitals in rural Manitoba report no registered nurses. The Manitoba Association of Registered Nurses reports a shortage of 267 general duty nurses. Several hospitals have had to close some departments for lack of nurses. This problem is of major importance and should be given first consideration. Why, then, urge the immediate erection of new hospitals until this problem is solved? If new hospitals are staffed, it will just be at the expense of existing hospitals. This is poor policy."

About one year earlier the Commission, realizing the seriousness of that situation, recommended to the Minister that he set up a committee to study the problem. This he did immediately, with the writer as chairman and with representation from the

nurses' association and the Department. The Committee first met on June 20, 1946, and in January submitted an interim report to the Minister. This report contained these facts:

Information secured from 29 hospitals outside of Winnipeg (three hospitals representing 93 beds failing to make a return) showed 1,137 adult beds and 267 bassinets. Full quota of nurses required to staff these beds, 238—a shortage of 71 (a shortage of 95 according to the standards of the National League of Nursing). Moreover, there was a need of 17 practical nurses. The report also

drew attention to the unsatisfactory working and living conditions of nursing staff.

A second survey made by this committee in September, 1947, with 45 public hospitals reporting, including sanatoria, showed a need of 4 matrons, 36 ward supervisors, 157 staff nurses, and 125 practical nurses—a total shortage of 322.

Another survey in January, 1948, showed 109 staff nurses short as compared with 157 in September, 1947, and a shortage of 74 practical nurses as compared with 125 in September, 1947. This improvement was due, apparently, to the fact that hospitals are always better supplied with nurses during the first three months of the year.

It was also learned that assistance for nurses entering training was available from three sources: (1) loans from Dominion - Provincial Student Loan Fund; (2) Dr. E. W. Montgomery bursaries; (3) Dr. Robert Fletcher scholarships.

M.A.R.N. Report

The Manitoba Association of Registered Nurses reported on December 31, 1946, that in 1945 they had 1,945 active paid-up members and that Reg.N. diplomas were granted in 1944 to 297 nurses, in 1945 to 334 nurses, and in 1946 to 318 nurses. There had been removed from the

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Merry Christmas

This little corner is reserved to bring greetings to all our friends and readers, whether they be here in Canada or far beyond our borders. May it be a season brimming with joy and happiness and may the New Year, in extending the spirit of service, bring peace and prosperity to all.



Ami-lecteur:

Que les Fêtes soient une occasion de profonde réjouissance et que le Nouvel An vous apporte paix et bonheur.



Estimate of Nurse Shortages

General Hospitals and Public Health Nursing, Manitoba

| Particulars | Rural Hospital Districts | Winnipeg Hospital District | Estimated Replacements at 25 per cent | | Totals |
|--|--------------------------|----------------------------|---------------------------------------|-------------|--------|
| | | | Gen. Hosp. | P.H. Nurses | |
| At present time | 55 | 42 | 155 | 27 | 279 |
| When present construction completed | 102 | 102 | 180 | 27 | 411 |
| When approval projects implemented | 142 | 170 | 205 | 27 | 544 |
| When schemes under consideration are implemented | 168 | 170 | 212 | 27 | 577 |

Fig. 1

"When you look at these figures do you wonder that I stress the need of dealing with this problem before proceeding with the building of new hospitals?"

“Ma Charité Est Avec Vous”

DANS un monde que les idées subversives tendent à diviser de plus en plus en y fomentant la haine et la discorde, il fait bon s'arrêter à la sereine et reposante pensée de la charité chrétienne.

Reine au ciel et sur la terre, la Charité voit briller à son royal diadème les précieux joyaux des autres vertus puisque, ainsi que le dit l'Apôtre, elle est patiente, elle est bonne, elle ne s'irrite point, elle excuse tout, elle croit tout, elle espère tout, elle supporte tout.

Dans nos centres hospitaliers, où la souffrance humaine a élu son domicile, nous formulons le souhait que personne ne s'approche du patient sans être revêtu de cette royale parure. Compréhensive et douce, que la charité de chacun se forme sur le modèle présenté par Saint Paul.

Mais la charité ne peut et ne doit pas s'arrêter sur le plan de la simple philanthropie naturelle si elle veut être productrice de bonheur pour les autres, de mérite pour nous, si elle veut, en un mot, être rayonnante. Elle doit se greffer sur la charité du Christ Jésus, dont nous fêterons bientôt la naissance. C'est en Lui seul que notre charité trouve sa signification la plus vraie et la plus haute, puisqu'elle se perd dans l'infini de la divinité.

Lorsque nous aurons compris quelque chose de l'immense amour qui a conduit Dieu à se revêtir de notre chair mortelle et à naître pauvre et souffrant, nous aurons trouvé la réponse pratique aux problèmes inquiétants qui bouleversent l'humanité—la réponse, aussi, à ceux qui, chaque jour, dans le domaine hospitalier, appellent une solution qui ne sera juste qu'à la condition d'être marquée du sceau de la divine charité.

—*Rév. Hector L. Bertrand, S.J.*





"My Charity Be With You"

IN a world which subversive ideas tend to divide more and more, while at the same time fomenting hatred and strife, it is good to pause for a moment to contemplate the reassuring and heartening ideal of Christian charity.

Supreme in heaven and on earth, Charity from its royal diadem radiates other virtues like precious jewels. As the Apostle says, Charity is patient, it is kind, is not provoked to anger, it beareth all things, believeth all things, hopeth all things, endureth all things.

It is our hope that in our medical institutions, where human suffering has chosen to make its abode, no one will approach the patient unless he be clothed in this royal robe. May the charity of each be patterned on the model held out by Saint Paul, all-embracing and sympathetic.

But our charity should not and cannot remain on the level of mere human philanthropy, if it is to radiate happiness for others and yield merit for ourselves. It must be embodied in the charity of Jesus Christ, Whose birth we are soon to celebrate. It is in Him alone that our charity finds its truest and highest significance since there it loses itself in the Divine.

Only by understanding the boundless love which caused God to clothe Himself in our mortal flesh and come into the world poor and suffering, shall we find a practical answer to the disturbing problems which beset mankind. Only thus, too, shall we find an answer for those in the hospital field who seek each day a solution to their problems—a solution marked with the seal of divine charity.

—Rev. Hector L. Bertrand, S.J.

Current Trends in Construction Planning

Part I

Charles F. Neergaard,
New York, N.Y.

IN the past decade we have gained a new over-all conception of hospital and health care:

1. That for national well-being everyone is entitled to good medical care;
2. That the insurance principle offers the only practical method whereby people can pay for it;
3. That Government in the future will play a greater part in financing hospital construction and care of the indigent;
4. That the hospital system must be operated as a business, not a charity;
5. That the individual hospital can no longer go its own way but must become a unit of a co-ordinated community program designed to provide a balanced service for all.

The modern general hospital as the health centre of the community is far different from its prototype of a generation ago. The scope of its work has broadened and preventive measures are receiving emphasis, in order to detect illness in its early stages and to keep people well.

Larger general hospitals now frequently include:

- Accommodation for the local public health department;
- Ample provision for out-patients;
- Offices for Visiting Nurse Service;
- Blood bank;
- Consulting rooms and offices for the staff;
- Diagnostic clinics organized to reduce the cost to the patient;
- Preventive health examination clinics;
- Isolation units for contagious cases;
- Facilities for early treatment and rehabilitation of restorable chronics;

From an Address given to the Ontario Hospital Association in November.

The author is a partner in the firm of Neergaard and Craig, Hospital Consulting Services, New York.

Facilities for the examination and treatment of psychoneurotics in the early stages;
Facilities for alcoholics.

The last three represent a new attack on our greatest health problem. The Mental Hygiene Department of New York State is already supporting preventive work in general hospitals instead of spending all of its funds to build more mental institutions.

These additional resources, while enlarging the general hospital, will in the end save much money in the over-all community health budget.

The integration of the health department with the hospital will reduce overhead and duplication of personnel, laboratories and clinic space.

Prevention in the out-patient department and the early diagnosis and treatment of acute conditions, mental cases, and chronics will ultimately reduce the number of acute mental and chronic beds needed. Physical and occupational therapy will accelerate recovery. A co-ordinated hospital program will eliminate such extravagant duplications as I found in one city where three hospitals within a radius of two miles were each maintaining a cancer clinic with complete deep therapy equipment. Two of the departments were operated by the same technician. The entire volume of work could have been handled by one department working half-time.

New Thoughts on Planning

What we are all interested in is getting a sound, practical, workable hospital at minimum cost. If we challenge some of our traditional standards and re-evaluate some of our planning and construction practices

there are literally hundreds of ways that we can effect economies in the first cost of the hospital building without jeopardizing operating economy and maintenance which should always be the completely controlling factor in construction.

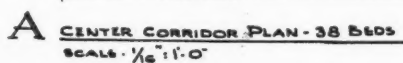
The consultant is alert to new needs and new and better ways of meeting old needs. Familiar with the practices of architects and engineers in many different hospitals, he can avoid the mistakes they may have made and adopt their constructive new ideas. Getting such information is one-half of the process; the other half is having it used. Unfortunately many of us are so busy planning new hospitals, that we do not always take the time to find out how our old ones have worked, and it is far easier and less time-consuming to continue old practices and to specify from the catalogue rather than to investigate new ideas.

Larger Nursing Units

The traditional nursing unit has usually 30 beds. Many have been planned disastrously with less, a few with more. Irrespective of how many or how few beds there are each unit must have complete facilities for patient care, nurses, stations, utility rooms, treatment rooms, pantry, solarium, toilets, baths, bedpan and flower rooms, linen, stretcher, wheelchair and storage closets. These facilities and their equipment, together with corridors and stairs, bulk large in cost and space as compared to the area occupied by patients.

Some authorities advocate 25 beds to a nursing unit. A large majority of the American Association of Hospital Consultants concur in the suggestion that 38 to 40 beds is practical and that, given a compact, well-designed plan, the nursing service can be organized effectively to handle the larger load.

A 150-bed hospital with six 25-bed nursing units, according to the plans published by the U.S. Public Health Service, has an average of 179.9 sq. ft. per bed in the nursing department, exclusive of corridors and stairs. The nurses' stations are 85 to 90 feet from the farthest bed. If the 150 beds were arranged in four units of 38 beds each the comparable area in one well-studied plan averages but 141 sq. ft. per bed with no increase in the nursing travel. The major economy would



Medical Services in the Highlands and Islands

THE most interesting development of the Health Services in Great Britain under the Acts of Parliament, passed in 1946 to establish a national organization in each country, is to be found in the Highlands and Islands of Scotland. The medical service which has been operating there for twenty years was the prototype of the organization which has now been made applicable in England and Scotland. Moreover, it is of particular interest in connection with conditions in Canada as there are some similar features. A journey by water through the lochs among scattered islands is reminiscent of the Canadian lakes. Distances may not be so great but there are small isolated groups requiring medical and nursing care.

Challenging Area

Their need first began to attract

C. E. A. Bedwell,
London, England

attention just one hundred years ago. In 1850 the Royal College of Physicians in Edinburgh found that on the west coast of Sutherland, with a population of 5,000 in an area of 60 to 70 miles, there was only one doctor; and in the islands medical attention was even more inaccessible. Since that time there has been a steady improvement though even now it is not an easy job to run a medical practice in that area. A recent correspondent to *Lancet* (23rd July, 1949) warned students who were thinking of doing so that:

"They must be prepared to do rounds on a motor-cycle (despite recent pronouncements of the Minister) and even ride on horseback to lonely farms for confinements. They must

not only be prepared to use a motor-boat but know something of the dangers of the sea lochs. They must care and continue to care for cases which cannot be taken to hospital by one ambulance only but whose transport may be a matter of rowing-boat, steamer, and motor ambulance. And they must know Gaelic. The number of people in Scotland who can talk no English is now very small. But when it comes to ministering to children in pain or to the old in distress, it is in Gaelic that the sufferers will complain, and in Gaelic that the soothing words are spoken."

Early Health Insurance

A definite stage in the advance took place upon the introduction of national health insurance in 1911. Crofters, cottars, and fishermen could not benefit by it as the medical service was not available for them. A special Act of Parliament was passed in 1913 to provide a subsidy for the medical men but the first world war intervened to prevent it from becoming effective. Under the Act the amount made available by the Department of Health was £42,000, increased by further legislation in 1929. Now the service has become absorbed in and is financed by the National Health Service, for which it provides a solid foundation in the north-west portion of the Kingdom. At the time the particular effect of the action taken by Parliament was to provide



Glen Coe House, built by the first Lord Strathcona and at present used as a maternity home, is delightfully situated in the famous glen.



Fort William, with its Belford Hospital, nestles at the foot of the mighty Ben Nevis.

by State subsidies remuneration for medical men in areas too poor to furnish them with an adequate income. The same principle is contained in the English legislation about which there was so much controversy, although it has worked with complete satisfaction for the medical man in Scotland. In fact, whenever there have been vacancies in the medical service there has always been an excellent choice of candidates. As a consequence of this existing organization, although the Scotsman is far more independent than the southerner, the Act has been brought into operation with less trouble than in the south.

The grants made under the original scheme enabled the doctor to render medical service to the members of the family who contributed according to their means and to which they are now entitled free by the new law. The grants from the Fund were assessed by the amount of work as measured by the travelling involved in attending beneficiaries under the scheme. The new Act will enable this scale to be revised as the remuneration received by some men is quite inadequate for the amount of work demanded of them. In addition, grants might be made for improving and building doctors' houses.

The Department's grant was also available for the improvement of the nursing service and was mainly administered through the voluntary nursing associations which have established a reputation for maintaining an admirable service noticeable for its

educational influence among the people.

New Organization

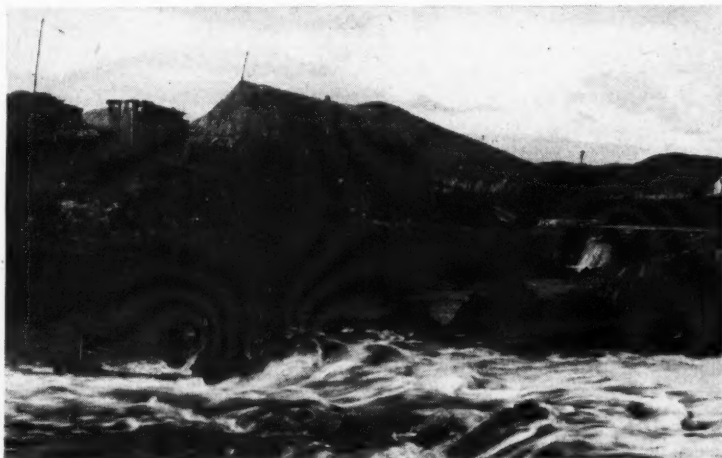
Under the new Act, although voluntary committees are still taking some interest in the domiciliary nursing services, especially in the towns, the administration is entirely under the local authorities who are also completely responsible for the expenditure. In this, Scotland differs to some extent from England where a large proportion of the local authorities have delegated their statutory responsibility for the home nursing service to the former voluntary bodies while meeting the whole or major portion of the cost. Another

point in which the two services differ is that Scotland does not employ health visitors to the same extent as in England.

The new regional organization under the National Health Services Act has terminated in law, if not in fact, the Highlands and Islands Medical Service. The division into regions has to some extent severed old attachments though it is a recognized feature of the organization that patients may be transferred from one region to another. Good fortune took me to Ballachulish which provides an excellent example. It is on the borders of Argyllshire where it is joined by a ferry to Invernesshire. The village is pleasantly situated and nearby are the largest slate quarries in Scotland which have been worked for nearly two hundred years. It is an area centering upon Oban where there is a small general hospital. The group, which is in the Western Region, also includes three isolation hospitals, a county sanatorium, the West Highlands Rest for the elderly and aged, and Glen Coe House which since the war has become a maternity home. The house was built by the first Lord Strathcona of C.P.R. fame and is in a beautiful situation in the famous glen. Two wings were removed some time ago and the remainder has recently been sold by a member of the family to the local authority. Presently it has accommodation for only eighteen mothers, but, although the maternity service is



Picturesque Ballachulish Ferry from the south. Beyond is the Northern Hospital Region.



A crofter's cottage on Leverburgh Isle of Harris where Harris Tweed is spun and woven by hand. The cloth can be seen drying on the left end of the cottage.

Presentation of Stephens Memorial Award

A SPECIAL feature of the British Columbia Hospitals' Association Convention was the presentation of the first George Findlay Stephens Memorial Award. Dr. A. K. Haywood was the recipient honoured by this award, which has been set up by the Canadian Hospital Council. In a fitting ceremony, conducted by R. Fraser Armstrong, President, with the assistance of Father Bertrand and Percy Ward, a suitably engraved gold watch was presented to Dr. Haywood, together with a citation which read as follows:

"The Canadian Hospital Council takes great pleasure in bestowing upon you the first George Findlay Stephens Memorial Award for noteworthy service in the field of hospital administration.

"You have long been a leader in hospital work. Throughout your administrative career in Toronto,

in Montreal, and in Vancouver, you have maintained the highest traditions of those who have devoted their lives to administration. Your services in founding the Montreal Hospital Council, in guiding the work of the Department of Hospital Service of the Canadian Medical Association, in helping to found the Canadian Hospital Council, and in serving conscientiously on the governing bodies of the British Columbia Hospitals' Association, the American Hospital Association, and the College of Hospital Administrators, as well as of various other local and national organizations—all these services bear testimony to your public spirit, your breadth of interest, and your constant willingness to help your colleagues and your fellow-citizens.

"Not the least among your many



Dr. Haywood (right) is congratulated by the President.

contributions to the hospital field, to your community and to the national effort during two Wars and the years of Peace, has been your training of a succession of assistants, whose many achievements and honours must have been a source of just pride to their preceptor.

"On behalf of the Canadian Hospital Council, you are herewith presented with the George Findlay Stephens Memorial Award and this Citation."



still necessarily and primarily domiciliary through district nurses, the delightful home is naturally becoming popular in a wider area, e.g., in nearby Kinlochleven with its busy industrial population. To have a home of this kind available, with an admirable theatre, and in the charge of a well qualified matron, who can call upon a local doctor with special obstetric experience, is an ideal arrangement. Unfortunately, being under the Regional Hospital Board, it is called a hospital which is really a misnomer and emphasizes, what to some of us seems a weak point, that maternity is to an increasing extent regarded as a cause for hospital accommodation.

The Islands

On the northern side of the Ballachulish Ferry is the Northern Hos-

pital Region and the Belford Hospital at Fort William, lying at the foot of Ben Nevis the highest mountain in the British Isles, is the only one serving the area surrounding it. To it also resort the sick from Lewis and Harris and the outer islands. Stornoway, the chief town in the former, is famous as the birth place of Sir Alexander MacKenzie, who was the first white man to cross the Atlantic from coast to coast and gave his name to the Mackenzie River. In the town hall is a tablet commemorating Robert Macauley, founder of the Sun Life Assurance Company of Canada. The twin island of Harris is known all over the world for its tweed industry. The Highlands and Islands provide a noticeable example of the problem which confronts Scotland as a whole. Fair Isle which is equally well known

for its beautifully patterned jerseys is typical. The population of the island, acquired in 1948 as a bird sanctuary, is less than one hundred. The purchaser, Mr. George Waterston of Edinburgh, stated that his principal aim in taking over the island was to do all in his power "to assist in maintaining a virile, happy, and industrious community there. The most important export trade of the island is the characteristic hosiery which bears its name, and it will be my earnest endeavour to foster the knitting and sale of the genuine Fair Isle hosiery and protect it from its many imitators. By opening a bird-watchers' hostel on the island I hope to attract visitors who will provide an outlet for the sale of the islanders' hosiery and produce." This Northern

(Concluded on page 78)

Voluntary Workers Receive Encouragement

THE interest and enthusiasm shown at sessions of the Western Canada Institute in Regina by the auxiliary members was evidence of the zeal of voluntary workers everywhere. Voluntary efforts have been responsible for every community betterment. The spiritual life of any group can be judged by the effort put forth to better, not only their own community, but mankind as a whole. It is easy for one to give voluntarily to one's own family, but real Christianity is shown when all indigent and aged, sick and injured, are our concern. The cry of pain and fear is understood in every language and differences in colour, class, and creed have no place in Christian service.

The extent of state control in public services is a matter of deep concern to the people of Canada today. Indifference is a disease which is killing democracy. There is a general tendency to leave the work to someone else—in other words—let George do it. If we do not grasp and keep hold of our own affairs, we are leaving ourselves open for state control. It is easy to see the value of our health services such as mental, tuberculosis, and cancer care. Previous to government care for tuberculosis cases, needy patients were cared for at home, thus endangering the lives of all who came in contact with them. Cancer cases were not looked after until so far advanced there was no hope of cure. Mental cases cared for at home caused constant nervous strain to the people concerned.

We have government hospitalization in Saskatchewan and, though I am not carrying a brief for the government, the point I wish to make is this—government control of hospitals does not eliminate the need for volun-

**Mrs. J. L. Robertson,
Davidson, Sask.**

tary work. Rather where the hospital aids or auxiliaries are concerned, it gives them a wider scope.

In the first year of our hospitalization plan we found a great deal of misunderstanding among the general public as to whether or not their own hospital received full benefit from their donations under our present hospitalization plan. This misunderstanding had to be cleared up if our hospitals were to continue to receive voluntary community support. I would like to emphasize that our hospitalization plan does not impair the usefulness of our hospital auxiliaries in any way.

Many people are under the impression that the Saskatchewan Hospital Services Planning Commission pays for the operating of our hospitals. Actually, our local hospital boards are managing and financing hospitals on the revenue received from the Commission. The revenue is derived from a patient day-rate. The patient day-rate is based on normal efficient operating expenses of the hospital plus depreciation on buildings and equipment. We are finding that many of our small hospitals are not economical units as they must be occupied to full capacity in order to meet their expenses. Deficits are almost inevitable. So in the past the Commission has paid up to 80 per cent of any operating deficit. The community must raise the balance.



From an address at the Manitoba Hospital Association in October. Mrs. Robertson is past president of the Saskatchewan Hospital Aids Association.

The community is also responsible for new items of equipment. In time the depreciation on equipment will replace it, but the initial capital cost must come from the community. Voluntary gifts from hospital auxiliaries help the hospital boards to meet the community's share of such deficits or the cost of new equipment.

In the present financial setup of our hospitals, donations received are not considered by the Commission as operating revenues, while on the other hand all goods and services used in the hospital are regarded as operating expenditure, regardless of whether such goods were purchased with hospital funds or donated by an organization or an individual. Every item donated by a hospital aid is reported to the secretary of the hospital board. He records it as operating expenditure and credits the value of such items to donation.

I have gone into detail to explain our hospitalization plan as I wanted you to realize that, regardless of what a government may do, the real test of democracy is the ability of people to work together for the common good. Our Saskatchewan hospital aids have stood the test. They have shown that the interest in their hospitals will continue. In fact, the Hospital Services Planning Commission freely admits that the hospital aids meet a need which it would be exceedingly difficult for the Commission to fill.

Our Saskatchewan Hospital Aids Association was organized in 1941 under the guidance of Dr. Harvey Agnew of the Canadian Hospital Council. There were twelve hospital aids represented at the organization meeting; forty-five aids were represented at our convention this year. We have a membership of sixty-four groups in our association. Only forty-nine sent in reports this year and the sum of over \$40,000 was raised and spent on our hospitals by those reporting. There have been so many new hospitals and nurses' residences built this year that our auxiliaries have been kept busy supplying furnishings for these buildings.

Aid representation on hospital boards is one of my pet themes for,
(Concluded on page 84)

Proposed Government

Hospitalization Plan

Announced at Alberta Meeting

A HIGHLIGHT of the 1949 convention of the Associated Hospitals of Alberta, held in Edmonton last month, was the announcement by the Minister of Health, Dr. W. W. Cross, of a proposed municipal hospitalization plan. The scheme, as outlined by Dr. Cross, is similar to but distinct from the municipal hospitalization plan which has already been implemented in many parts of the province, and is much more generous to the municipalities. In essence, the new arrangement would mean that the patient would pay \$1 per day for hospitalization and the government would continue its grant of 70 cents per day; the remainder of the public ward rate would be shared equally by the municipality and the provincial government. This plan, if endorsed by ratepayers, will also provide a self-supporting hospitalization contract for non-ratepayers whereby they may obtain public ward service at \$1.00 per day. It is expected that the plan will go before the legislature in February.

The proposed legislation was well and thoroughly discussed by hospital delegates and, while many criticisms were voiced, hospital authorities were gratified at this evidence of the government's willingness to lend more ample assistance to the municipalities, and general good-will was shown. (See resolutions below).

The convention as a whole was one of the finest and most productive ever held by this young and enthusiastic association. With a membership of 98 hospitals, there were over 200 delegates present and debate was rapid in every session.

With respect to the shortage of

nurses, Dr. A. C. McGugan, in his presidential address, made the very practical suggestion that girls who are interested in nursing but have no funds for training be given a \$400 loan by the provincial government. Miss Frances U. McQuarrie spoke with clarity and distinction on the subject of present-day nursing, its advantages and disadvantages. In reporting on the Alberta Health Survey, Dr. A. Somerville referred to the nursing problem as the "bottle-neck of the whole health field" and R. Fraser Armstrong, President of the Canadian Hospital Council, urged some method of assisting nurses' aides to obtain the higher scholastic standing required to enable them to enter the profession proper.

One subject on which Albertans waxed eloquent with indignation was the problem of federal government payment for the hospitalization of Indian patients. James Barnes, chairman of the Economics Committee, recommended that "the Dominion Government be advised that, until we are satisfied, hospitals will not admit Indians as patients, except in genuine emergencies". The Association is fighting for payment of public ward rates of \$5.50 per day, plus extras of \$3.50, whereas the Indian Health Services, D.N.H. & W., has been paying amounts varying from about \$2.50 to \$5.

Among many excellent addresses, one which roused much interest was "The Role of Therapeutic Dietetics in the Treatment of the Patient" by Miss Margaret Lang, Director of Dietetics at the University Hospital, Edmonton. Dr. E. P. Scarlett of Calgary, speaking on the responsibilities of

the hospital to the medical staff, stressed that initiative, imagination, and the humanizing touch, were qualities hoped for in an administrator. R. Fraser Armstrong gave a stimulating and informative address entitled "The Canadian Hospital Council—Its Contributions to the Welfare of Canadian Hospitals".

Resolutions

Among the resolutions approved by Association delegates were those:

1. Recommending the appointment of a committee of four, representing municipal, church, city, and all other approved hospitals, to assist the provincial department of health in drafting regulations under the considered legislation which proposes to assist municipalities in providing public ward hospitalization for their residents.

2. Recommending that, when the term of the present Alberta Health Survey Committee expires, a similar committee be appointed to carry on.

3. Urging the federal government to extend construction grants to include nurses' residences and service departments.

4. Requesting that due credit for previous nursing aide training be given to girls admitted to training schools for nurses.

5. Calling for an amendment to the Municipal Hospitals Act making provision for a gratuity to hospital employees retiring after 20 or more years of faithful service and not covered by a pension scheme.

6. Urging the federal government to pay, for the hospitalization of Indian patients, the "going rate" of public ward accommodation, plus fees according to a set scale for extra services.

Officers Elected

Hon. Pres.: Hon. W. W. Cross, M.D., Minister of Health

President: Frank Swain, High River

Vice-pres.: Edgar E. Dutton, Lethbridge

Sec.-treas.: L. R. Adshead, Edmonton

Chairman, Economics Committee: S. H. Edwards, Bassano

Chairman, Blue Cross Board of Trustees: A. C. McGugan, M.D., Edmonton

The Hobby Corner

17. Ocean G. Smith

WHEN asked to comment upon his hobby, choral singing, Ocean G. Smith, consulting accountant to the Ontario Hospital Association, sent us the following modest account of his activities:

"Many people love to sing but not all are endowed with voices suited to the concert or operatic stage. For these, church and secular choirs offer a satisfying outlet. Of the latter, the Toronto Mendelssohn Choir, consisting of some 200 voices, is probably the best known in North America. To qualify as a member of this famous organization, one is required to possess (a) a voice of good quality, (b) the ability to read music at sight, and (c) a background of musical training.

"Back in 1920, I somehow succeeded in satisfying the late Dr.

H. A. Fricker on these three points and have continued as a member ever since. The current season 1949-50 will be my 30th year of membership. For the past 17 or 18 years I have been a member of the Executive Committee and last



season was prevailed upon to assume business management of the Choir following a short trip to Ottawa and Montreal where the Choir sang to appreciative audiences. Plans for this season include, in addition to customary performances, a Bach festival in April to commemorate the 200th anniversary of the death, in Leipzig on July 28, 1750, of the great Johann Sebastian Bach."

Mr. Smith omitted to mention that last year he compiled a brief and illuminating history of the Mendelssohn Choir, tracing its growth from the year 1894 to the present day. The three chapters, graphic vignettes of the lives and achievements of the three great leaders of the Choir, are devoted in turn to Dr. A. S. Vogt, founder and conductor until 1917; Dr. H. A. Fricker, conductor until 1942, and Sir Ernest MacMillan, who wields the baton not only of the Choir but of the Toronto Symphony Orchestra as well. An impressive chronology of out-of-town appearances reflects the warm reception and welcome accorded the Choir time and again.

As a tribute to the loyal devotion of Mr. Smith to his "hobby", there appeared in the *Mendelssohn Chorister*, following the tour east last year, this comment by Sir Ernest:

"The Choir made a profound impression in Ottawa and Montreal. . . . Appreciation of Mr. Ocean Smith's admirable planning and management was heard on every hand during the trip, and the results were reflected in the happy atmosphere that prevailed throughout."



Food and Its Service

Sponsored by
the Canadian Dietetic
Association

CHRISTMAS DAY offers a challenge to each and every member of the hospital staff. All must see to it that details of the day's program are planned well in advance to ensure a peaceful and happy holiday occasion.

Christmas meals and festive decorations do much to create the Yuletide atmosphere and a fair percentage of the staff should be on hand to decorate the wards and dining-rooms. Traditional decorations and colour schemes please most people for their informality and warmth lend a homey touch. If dining-room tables are small, a side or serving table may be placed in a conspicuous spot and the main decoration concentrated there. Where fire regulations permit, a Christmas tree will provide a most effective centre of interest. Decorate the walls with holly wreaths and pine and cedar boughs, bringing indoors the tangy freshness of evergreens. Twine pillars with twisted red and green ribbons or evergreen ropes and from them hang Christmas stockings filled with after-dinner favours.

Use a tablecloth at Christmas, even if you must borrow sheets from your hospital laundry. Gay paper cloths, too, are attractive backgrounds for your table decorations. Wide coloured streamers, Christmas menus, serviettes and candy baskets at each place,

and an attractive centre piece show up effectively against a white cloth.

In choosing your table centre, you will have great scope for displaying your ingenuity. A Santa's sleigh drawn by reindeer and loaded with favours, a Yule Log decorated with painted pine cones, ribbons and bells, Jerusalem cherry trees, and potted

silver or gold doily, may be cranberry juice or apple cider coloured with cochineal. A cherry frozen in the centre of a coloured ice cube adds another festive touch.

Tray service presents a different problem because here space for extras is so limited. Sugar cubes may be wrapped in red paper in the shape of a cracker and labelled "sugar". A small candy cane tied with a bit of holly and a gay parcel tag for tray card can also brighten up the tray. Place over the hot plate cover at dinner a replica of Santa's famous cap (Fig. 1). This is simply made by fashioning a cone of red paper to fit the cover, creasing over the tip, and trimming with a pom pom and band of absorbent cotton.

Wrap the piece of Christmas cake in coloured cellophane, topped with a sprig of holly or tied up as a gay parcel in wax and tissue paper with seals, ribbon, and tag.

Apple Santa Claus

Some hospitals honour the traditional apple Santa Claus on the breakfast tray (Fig. 2). However, for those who have not hitherto observed this custom, here are the directions: Select a round, red, and well polished apple. Fasten to it with a half a toothpick marshmallow arms and legs and a puffy marshmallow face with cloves for eyes and nose, and a broad Christmas grin marked with red pencil. A beard of absorbent cotton shaped to a point and tucked under the chin, a hat of red construction paper with a marshmallow or cotton tassel, and an absorbent cotton belt held in place with a gold paper buckle, complete the jolly figure. Santa can be put together in a hurry if the parts are made beforehand and stored in air-tight containers.

Candy Basket Favour

To make a candy basket which is simple to use and yet novel, you require a small paper cup, some red and green construction paper, and red show card paint. Paint red vertical or triangular bands around the out-

Dressing Up for Christmas

H. Elizabeth Balfour,
Toronto, Ont.

Christmas trees about 18 inches high, are some attractive possibilities. Balloons may not be traditional decorations but they are always associated with parties. Try making a heavy cardboard Santa about 8 inches high with balloons fastened to his hand.

At each place on the table set a Christmas menu (which may be the place card as well), a serviette and cracker, and a wee basket filled with candy and nuts. The cocktail, on a

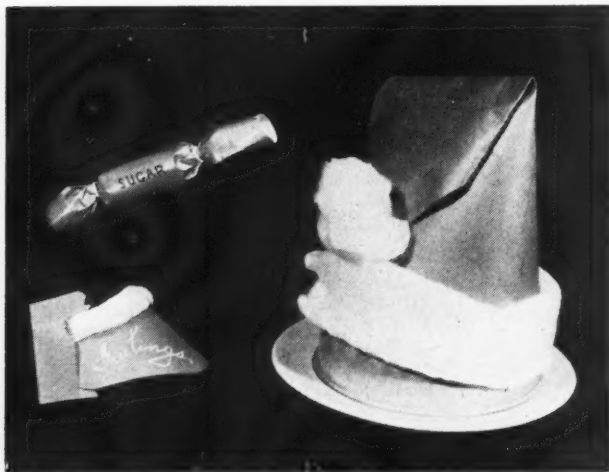


Figure 1

side of the cup and fit a decorative collar on the top. The collar is made by drawing on each piece of coloured paper a circle exactly the size of the diameter of the cup, cutting out the centre so that the collar will fit snugly around the top of the cup. Scallop the edges of each collar, about an inch deep at the widest point and arrange them so that a scallop of one colour shows below that of another.

Christmas Tree Favour

Choose a sprig of evergreen about five inches high to fasten in a marshmallow which has been reinforced with a strip of coloured or gold paper. (Fig. 3). Complete with small bits of marshmallow clinging to the branches as snow and a tiny Christmas seal star or angel.

Santa Claus Shoe

This attractive menu-favour is cut from red construction paper in the shape of a stocking, with an 8-inch leg and 5-inch foot. The menu, printed with red ink on white paper, is stapled at a fold diagonally across the heel and at a second fold two inches from the top of the stocking. The toe is inserted in a slit just below the top of the stocking to form the Santa Claus Shoe (Fig. 1), and, with a strip of absorbent cotton for a cuff and a little white show card paint for "Greetings", the shoe is complete.

Toboggan

Curl back one end of a strip of red velour cardboard $3\frac{1}{2}$ by 8 inches and slip a rope of braided Christmas twine through the curve (Fig. 2).

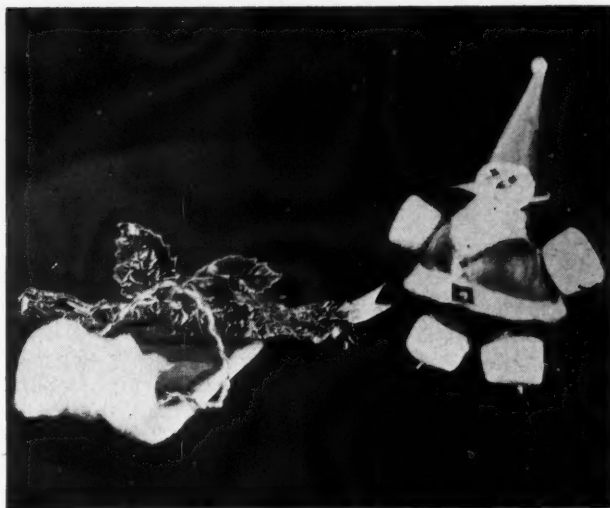


Figure 2

Paste a thin layer of absorbent cotton along the outer length of the toboggan and attach either a candy basket or a "Christmas cracker" to it. The cracker is actually a printed



Figure 3

menu rolled up in red metallic paper decorated with a sprig of holly. On the "puller", a strip of heavy paper, is printed this little verse:

*This little cracker brings to you
In manner that we trust is new,
A souvenir of Christmas Day
The menu in a wrapper gay.*

Picture-Menu

While you may not be an artist, you can easily make a picture-menu. First make a pattern by tracing an interesting scene or object from a Christmas card or magazine, then draw the outline on the menu, and fill it in with colourful show card paints.

Whatever you choose to do you will find your efforts well rewarded with the pleasant smiles and greetings of patients and staff.

O.H.A. Welcomes New Pharmacy Section

This year the Ontario Hospital Association, meeting in convention at Toronto from October 31 to November 2, welcomed a new section, the hospital pharmacists of the province.

Highlighting the sessions of the meeting were addresses by Charles Hammond, Phm.B., Narcotic Control Division, Ottawa, and W. Arthur Purdum, Ph.D., Johns Hopkins Hospital, Baltimore. In discussing "Narcotic Control within Hospitals", Mr. Hammond urged

that hospitals exercise adequate control of narcotics to prevent supplies being directed to illicit channels. Dr. Purdum, pointing out how efficiency and economy may be effected in a hospital pharmacy, gave concrete examples of saving by an intensified manufacturing program.

Summarized in part, the resolutions recommended that:

(1) all hospitals provide pharmacy services, full service being in the ratio of one pharmacist for each 100 beds;

(2) under the point rating system (now being used by the A.C.S.

for approval purposes), the hospital pharmacy be considered an essential rather than an adjunct service;

(3) a uniform system of accounting be adopted for pharmacy departments; and

(4) in hospitals with nurse training schools, it be the pharmacist's duty to teach pharmacology to students.

Officers for the coming year are:
President: J. F. Cook, Oshawa
Vice-pres.: Harold Hicks, Toronto
Secretary: E. Amy Eck, Toronto
Treasurer: Mrs. Marjorie Graham, Toronto

B.C. Hospitals in Convention

Strengthen Association Ties

OVER 200 persons met, from November 17 to 18, in Vancouver to attend the convention of the British Columbia Hospitals' Association. Before the actual sessions got underway, a one-day pre-convention course was sponsored by the Association in collaboration with the Hospital Insurance Service. Lively discussion followed topical addresses on hospital finance and accounting under hospital insurance, and on identification of patients at the admitting office.

On the opening day of the convention, the Hon. George Pearson, Minister of Health, intimated that rising costs are embarrassing the government-sponsored hospital plan and asked delegates to make every possible effort to keep costs down through efficient administration. The opinion was expressed by administrators that costs can be kept on current levels, providing there is no general wage increase—since wages already account for 60 to 70 per cent of hospital costs.

R. Fraser Armstrong, President of the Canadian Hospital Council, outlined the activities of that organization. Later, at the nursing session, modern trends in nursing education were analyzed by Miss Ruth Morrison of the University of British Columbia; Miss Alice L. Wright, Reg.N., registrar, and Miss Margaret Cahoon, Reg.N., director of personnel services, R.N.A. of B.C., discussed problems pertaining to nurse registration and placement.

A special feature of the convention was the presentation of the first George F. Stephens Memorial Award to Dr. A. K. Haywood, Vancouver (see page 38).

Resolutions passed at the meeting may be summarized as follows: recommending that each member hospital pay the expenses of one delegate from its women's auxiliary; asking the B.C. Hospital Insurance Service to pay hospital rates of patients who are not

insured but should be; recommending the establishment of an administration course to include training in smaller hospitals and the recognition of previous hospital experience; raising the contribution to the Canadian Hospital Council to \$2,000; calling for a strengthening of the Association with a view to protecting the autonomy of the hospitals; setting up an arrange-

ment whereby pension schemes for hospital employees may be studied; recommending that hospital personnel problems be handled on a regional rather than provincial basis; requesting the B.C. government to underwrite the cost of training nurses and technical personnel.

The new slate of officers for 1949-50 includes:

President: A. H. J. Swencisky, Vancouver

1st Vice-pres., J. E. O'Mahony, Summerland

2nd Vice-pres.: George Masters, Vancouver

Hon. Treasurer: J. L. Murray, Anderson, M.D., Victoria

Exec. Secretary: Percy Ward, Vancouver.

Consultants Complete B.C. Survey

COMMISSIONED by the government of British Columbia to study hospital and health services in that province, James A. Hamilton and Associates of Minneapolis recently presented the report of their findings and recommendations for a 22-year program. The cost of implementing the plan in the next two years has been estimated at between \$15,000,000 and \$16,000,000. Once the plan is in operation, it is expected that costs will drop sharply and that the total outlay from the present time to 1971 will be less than \$2,000,000 annually.

Six Separate Hospital Regions

The basis of the plan is the establishment of six separate and fully integrated hospital regions in the province. In each district, small communities should establish community clinics and health centres, each clinic having one doctor and dentist, laboratory and x-ray facilities, public health offices, and several beds for emergency cases. Then in strategic centres, larger community hospitals with at least 50 beds would provide general hospital services. Finally, fully-equipped major hospital units should be located at Vancouver and New Westminster in Region 1; Victoria, Region 2; Prince Rupert, Region 3; Prince George, Region 4; Kamloops and

Vernon, Region 5; and Nelson and Trail, Region 6.

It was also recommended that there be a single base hospital in the province, operated in conjunction with the University of British Columbia's medical faculty. The report suggests that the 86 hospitals now operating in British Columbia be reduced to 59 by 1971, but the number of clinics, now listed at 10, be increased to 51.

Acute Beds

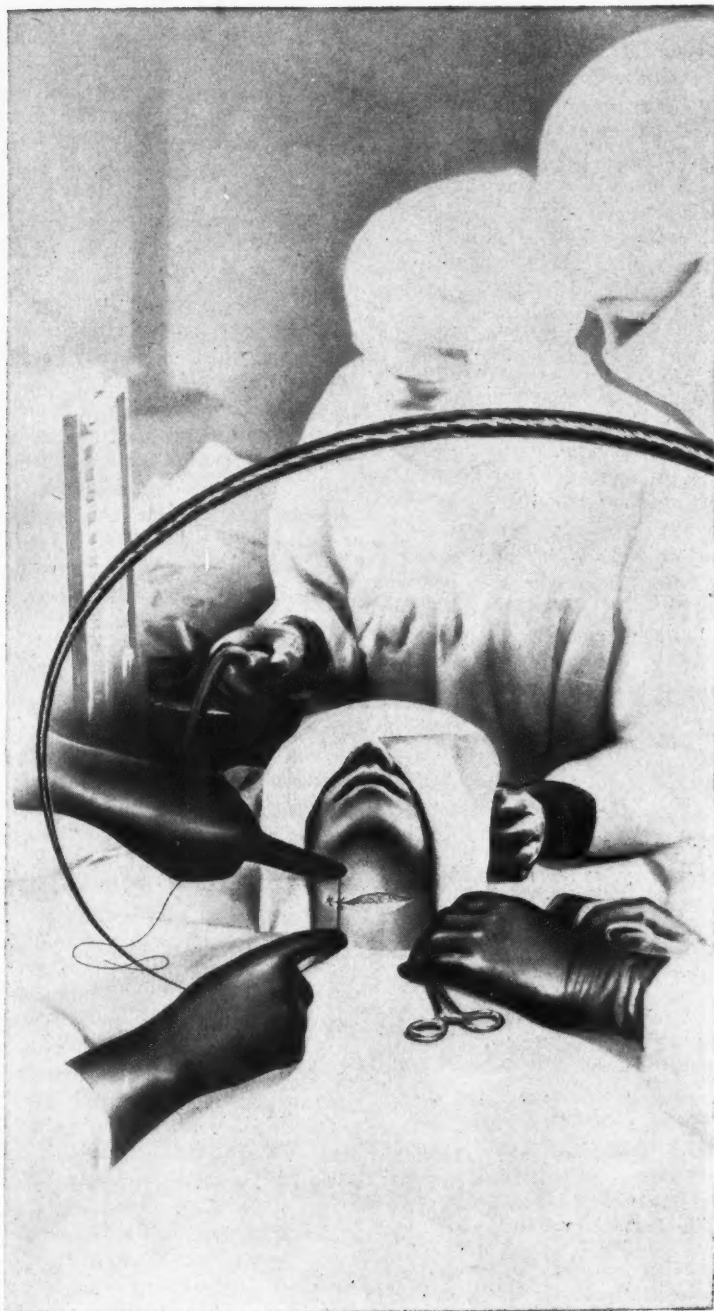
Of the 2,800 new beds recommended for the province in the next two years, only 1,100 would be in addition to present accommodation. The remainder will be necessary to replace present beds in hospitals where exist conditions of overcrowding or hazardous construction.

Chronic Beds

In the report, care of chronic patients has been classified as (1) treatment and rehabilitation for those who can be cured and (2) custodial care of those who, though not acutely ill, cannot look after themselves. Of the former group, the province requires some 2,000 beds by 1951, there being at present only 92. These should be built in conjunction with active treatment hospitals to avoid duplication of services and equipment.

(Concluded on page 74)

DEPENDABILITY.....



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Curity Sutures satisfy
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The quality of Curity Non-absorbable Sutures is high, uniform and constant. That's why surgeons rely today—as they have for many years—on Curity Sutures for all types of exacting operative work. It is *dependable performance* that has made Curity Dermal and Tension Sutures, for instance, the most widely used skin and stay sutures in current surgery.

Convenience, Economy

Curity suture packages are designed for convenience and economy. For quick emergency use, choose a sterile envelope or tube. When time is not a factor, save money with non-sterile boxes or spools. In either case, Curity Non-absorbable Sutures will meet your needs exactly.

Variety of Choice

Curity Non-absorbable Sutures comprise Dermal and Tension, ZYTOR—braided or single filament (the original suture made from nylon), Silk, Silkworm Gut and Horsehair Sutures. Choose from them according to your preference or need at your regular source of surgical supply. Rely on all of them for dependable performance!

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Curity
SUTURES

With the Auxiliaries

Ontario Aids Hold Convention Breakfast

The Women's Hospital Aids Association of Ontario held its annual meeting from October 31st to November 2nd in conjunction with the convention of the Ontario Hospital Association, with Mrs. Graham J. Harkness, presiding.

At the breakfast which opened the convention, Miss Priscilla Campbell, a former president of the O.H.A., spoke on "Telling Your Hospital Story to the Community". She pointed out that the hospital and the community take each other for granted, that someone must give the public a clear picture of the aims, responsibilities, and needs of the hospital, and she urged the Aids to assist in this work of public relations. Mrs. Joseph Ross of Truro, Nova Scotia, President of the Maritimes Hospital Aids Association, was a guest of honour.

One of the highlights of the convention was the presentation of honorary life memberships in the Association to Mrs. Ray Lawson, wife of

the Lieutenant-Governor of Ontario, and to Miss Eugenie M. Stuart, assistant professor of hospital administration at the University of Toronto.

At the business meeting on Monday, Hospital Aid societies gave their annual reports. The 60 groups belonging to the Ontario Association raised \$150,000 during the past year to help Ontario hospitals.

Mrs. Harkness was succeeded as president by Mrs. T. J. Lytle who, in her inaugural address, said in part: "We have a joint duty to perform and our best thoughts and actions are required to meet the hospital problems within the scope of our concern.

"It has been my privilege and pleasure to work with volunteers for many years, the people who go the second mile. A new field calls for mutual understanding and tolerance. Pleasure in our work is essential. Kipling in his poem *Fringes of the Fleet*, said,

*The game is more than the player
of the game,
And the ship is more than the
crew.*

"The hospital is our ship, and as an auxiliary crew we each have our own place to fill. Unity and clear vision is the strength of any organization."

Officers elected for the coming year were:

President: Mrs. T. J. Lytle, Toronto.

Recording Secretary: Mrs. P. M. Dewan, Ingersoll.

Corresponding Secretary: Mrs. J. C. Campbell, Toronto.

Treasurer: Mrs. Charles W. Sims, St. Catharines.

Public Relations Administrator: Mrs. O. W. Rhynas, Toronto.

* * * *

Public Relations a Challenge to Women's Auxiliaries

The original group of this Association* was called the United Aids Society, a fitting caption for the benevolent work this assembly stands for. We are now at the gateway of hitherto unthought of advances in the

field of hospitalization. Miracle medicines, miracle surgery, various new treatments, methods in nurse training, utilization of practical help, and last but by no means least, health plans—all of these are revolutionizing the entire hospital world.

This being so, if voluntary hospital aid members are to keep pace with the new day, we must all lend an attentive ear, learning facts helpful to us in appreciating what is required in the set-up of modern hospital services. Haphazard thinking and planning can only retard our work. To meet the challenge of our times it is necessary to acquire authentic information so that personal ideas may not handicap progress in building adequate community hospital and health services.

One most important phase is creating and conveying better understanding of the needs of the hospital field to the public. Never minimize the influence one individual can exert for or against any good cause. Good fellowship is infectious. Sincerity and diplomatic approach will eventually win where a flare of superficial enthusiasm will fade out.

Each member of every affiliated group can and should be an ambassador of goodwill for her hospital, knowing always when, where, and how to exert her influence for the weal of the best service. In other words, she does an intelligent public relations job in her community whether on the hospital board or actively helping to promote voluntary benevolence.

Public Relations, to my mind, is one of the most important media through which better understanding is conveyed to the citizens. Problems are clarified and factual data is given the proper perspective. When problems or misunderstandings are explained, solutions are more easily reached. Distorted propaganda can soon start a blaze to destroy good works at home or abroad.

General Omar N. Bradley, in a recent speech, would seem to have struck the right chord when he said. "We have grasped the mystery of the atom and rejected the Sermon on the Mount". The greatest public relations service we can render individually

(Concluded on page 48)

*From an address by Mrs. O. Rhynas, Public Relations Administrator of the Women's Hospital Aids Association of Ontario, at their 1949 convention.



Mrs. T. J. Lytle

Elected President of the Ontario Women's Hospital Aids Association for 1949-50, Mrs. Lytle has been for many years president of the Auxiliary of the Women's College Hospital, Toronto.



For SHORT ANESTHESIAS

with prompt, quiet, smooth recovery

WHEN short periods of anesthesia are involved, and it is desirable to have the patient ambulatory shortly thereafter, the use of the inhalation anesthetic agent Vinethene is recommended.

Vinethene anesthesia is rapidly induced and affords prompt, quiet, and smooth recovery. Nausea and vomiting are rarely encountered.

Vinethene anesthesia is especially useful as an aid to the reduction of fractures, manipulation of joints, dilatation and curettage, myringotomy, changing of painful dressings,

incision and drainage of abscesses, tonsillectomy, and extraction of teeth.

Vinethene also may be employed as an induction agent prior to the administration of ethyl ether and as a complement to nitrous oxide-oxygen anesthesia.

OTHER MERCK ANESTHETICS:

ETHER MERCK
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VINYL ETHER FOR ANESTHESIA U.S.P. MERCK

Available in 25, 50 and 75cc. bottles and packages
of 3-10cc. bottles with dropping caps

An Inhalation Anesthetic for Short Operative Procedures



MERCK & CO. LIMITED *Manufacturing Chemists*

MONTREAL
TORONTO
VALLEYFIELD



Montreal Aid Celebrates Jubilee

A Silver Anniversary luncheon marked 25 years of service for the Ladies' Auxiliary of St. Mary's Hospital, Montreal. Mrs. Leo O. Reynolds, president of the group which held its first general meeting in October, 1924, is shown above with a number of head table guests.

With the Auxiliaries

(Concluded from page 46)

ually or collectively is to stand up and be counted in supporting Christian citizenship, for sound judgment goes hand in hand with unselfish living and thinking. —Margaret Rhynas.

* * * *

Country Fair is Great Success

To help raise money to equip the hospital under construction at White-mouth, Man., the Hospital Guild at Seven Sisters Falls held a "country fair". The fair took place in the

community hall which was gaily decorated for the occasion. There was a huge haystack in one corner filled with gifts to be purchased, at a price, and a country post-office gave out interesting parcels in another corner. Fancy work was on sale, and games and lucky draws were held during the evening. The proceeds netted the guild over \$700.

* * * *

Celebrate 25th Anniversary

The Women's Auxiliary of the Victoria Hospital, London, Ont.,

celebrated their 25th anniversary last month. In honour of the occasion, the Aids held a banquet and a birthday cake was presented to them by the Victoria Hospital Trust.

* * * *

Aid Sells Calendars

The Women's Auxiliary of the Women's College Hospital, Toronto, is selling appointment calendars to raise funds. The monthly sheets are set up so that beside each date there is sufficient space to list appointments. At the bottom of each sheet, there is a reminder of the Aid's activities for the month. The calendars are attractive, as well as useful, and at the O.H.A. meeting last month they were selling like hot-cakes.

* * * *

Pledged to Equip Kitchen

The Women's Auxiliary of the new North Bay Civic Hospital has pledged itself to equip the kitchen of the hospital. The women expect the project to cost about \$15,000 and have already raised half this sum.

* * * *

Incubator for Calgary General

The Women's Auxiliary of the Calgary General Hospital has purchased an incubator as part of its 1949 contribution. The women are also making arrangements to present gifts to needy patients who are in the hospital at Christmas time.

B.C. Conference Delegates Attend 10th Annual Meeting

On November 14 and 15, delegates to the Catholic Hospital Conference of British Columbia gathered for their tenth annual meeting in St. Paul's Hospital, Vancouver.

Sessions were interspersed with informative reports, stimulating addresses, and round table discussions, and a scenic tour to St. Vincent's Hospital, Little Mountain, provided a pleasant diversion. Conference speakers included: Rev. H. L. Bertrand, President, Catholic Hospital Council of Canada, and Rev. J. A. Leahy, Conference Chaplain; Percy Ward and A. H. J. Swencisky of the British Columbia Hospitals' Association.

Officers on the board of directors include:

Hon. President: Most Rev. Archbishop Duke, Vancouver

President: Sr. Mary Ruth, Vancouver

1st Vice-pres.: Sr. M. Kathleen, Campbell River

2nd Vice-pres.: Sr. Bathilde, Comox

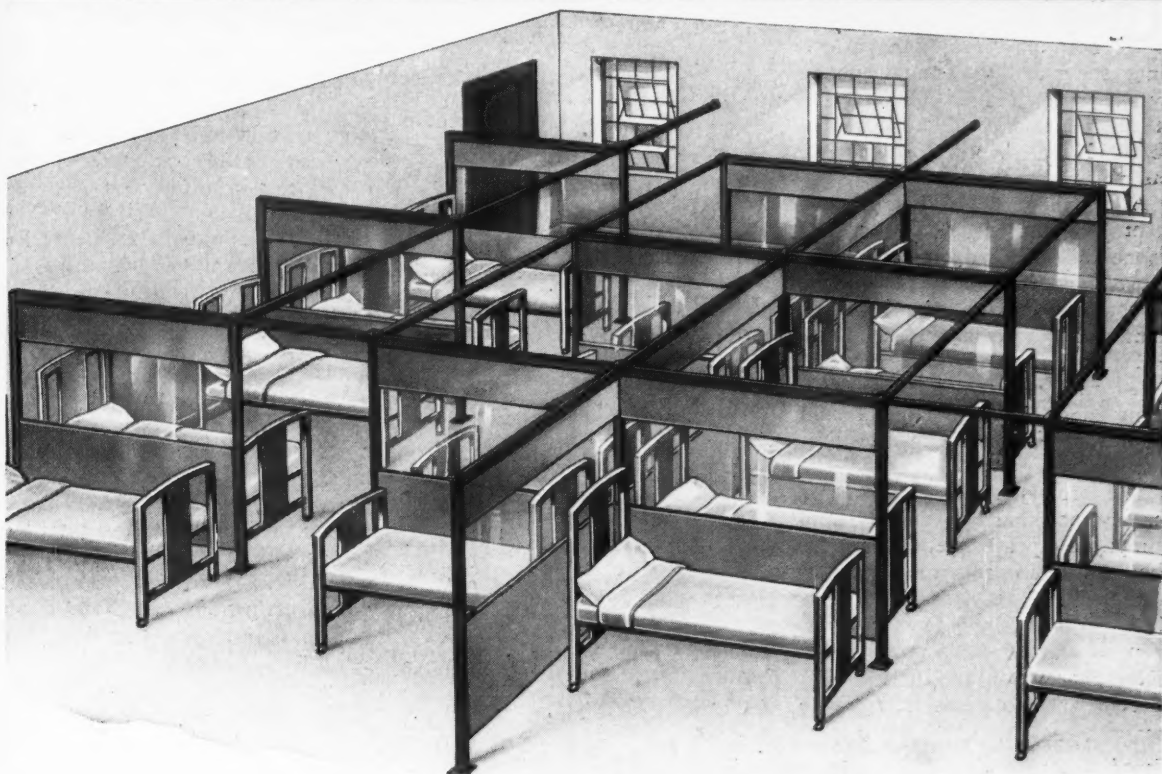
Secretary-treas.: Sr. M. Alexina, Vancouver.

St. Catharines Sponsors United Hospitals Campaign

On November 20, St. Catharines launched something new in hospital drives, "The United Hospitals Campaign". Not one but two hospital extensions are encompassed in the scheme, the St. Catharines

General Hospital, planning a 209-bed wing, and the Hotel Dieu, a new 125-bed general hospital.

The drive is organized to reach every citizen. In industry, employers are being asked for grants on a per capita employee basis; in turn employees are approached through a trade-union-approved plan, which asks each worker to give "two day's pay for a lifetime of health security". Emphasis is being placed on the fact that health insurance is worthless without adequate hospital accommodation and service facilities. Service groups, women's clubs, and fraternal organizations are taking part in this concerted community effort.



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Cortisone and ACTH

TREMENDOUS interest and hope have been aroused in both physician and patient since the startling announcement by Dr. Hench and his collaborators of the beneficial effect of Compound E on rheumatoid arthritis and rheumatic fever.

As in the case of insulin and later penicillin, demands for Cortisone and ACTH during this early phase of development far exceed the supply. In the meantime patients suffering from the rheumatic and allied diseases may rest assured that everything possible is being done in the clinical and laboratory field to expedite production.

The production of Cortisone is an extraordinarily difficult and complicated process requiring more than thirty separate time-consuming chemical reactions. To produce the compound from its first step to the finished product requires many months. In 1946 after more than two years of research

Dr. Graham is President of the Canadian Arthritis and Rheumatism Society.

Wallace Graham, M.D.,
Toronto.

by Dr. Kendall and his staff, Compound E was first synthesized in the Merck Research Laboratories. The amount accumulated from 1946 to January 1949, will have been virtually exhausted by the experimental and clinical studies which already have been completed and by the additional studies now in progress. The Cortisone which now is in production will not be fully processed until some time in 1950.

The effects of ACTH, the pituitary hormone which stimulates the adrenal, are clinically comparable to those of Cortisone if the patient has good adrenal function. This can be tested by the administration of 25 mgm. of ACTH, following which there is a drop of circulating eosinophiles of 50 to 80 per cent within four hours if the adrenal cortex has a good, functional reserve.

The essential difference between the two drugs is that the adminis-

tration of Cortisone simply raises the blood hormone level whereas the increase in the hormone level with ACTH will depend on the capacity of the adrenal gland to respond to stimulation. Naturally this response will vary with the potency of the ACTH used.

While the value of Cortisone and ACTH in controlling rheumatoid arthritis is regarded as established, much remains to be learned concerning their possible toxic effects, their usefulness in other diseases and the mechanism of their action. The small amounts available have been spread even thinner by increasing knowledge of possible beneficial effects in rheumatic fever, gout, dermatomyositis, disseminated lupus, et cetera.

In the meantime the president of the National Academy of Sciences of the United States has appointed a committee on the investigation of Cortisone with Dr. Chester Keefer as chairman for distribution of the available supply. Consideration is given only to requests from institutions where adequate facilities for investigation and clinical control are available.

The largest producer of ACTH at present is Armour and Company, Chicago, and in a similar way their supply is being distributed through their medical director, Dr. John R. Mote. Dr. Mote has also pointed out that at present none is available for treatment, but the drug is being issued to many research institutions where the effect on various syndromes is being carefully studied. The effective minimum dosage must still be established, and any possible harmful effects from prolonged use. Thus far, no cure has been reported, the symptoms recurring following cessation of therapy.

It is probable that new methods of synthesis will have to be developed before the drugs are generally available at reasonable cost. Until that time, for arthritic patients in particular, everything should be done to prevent deformity, ankylosis, et cetera, so that these irreversible changes will not be present when the drug becomes available.

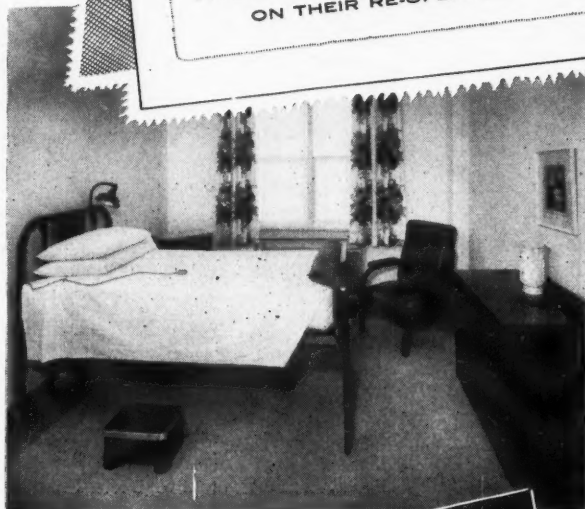
—Reprinted from "The Ontario Medical Review", Oct., 1949.



Christmas Seal

Last summer the motor vessel "Christmas Seal", so-called because it was purchased with Christmas Seal funds, covered more than 3,000 miles of Newfoundland's coast line. In its first year of operation, nearly 8,000 x-rays were taken, scores of visits paid to schools and homes, films on tuberculosis shown to approximately 4,000 people, and hundreds of pamphlets distributed.

Congratulations
TO THE
**WEST LINCOLN
MEMORIAL HOSPITAL**
ON THEIR RE-OPENING



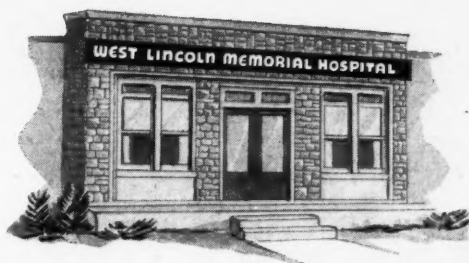
A typical private room with furniture in walnut finish.



Note the built-in Metal Craft instrument cabinet in Minor Operating Room — Metal Craft equipped throughout.



Shown right is a view of the modern kitchen facilities with Metal Craft sinks, cabinets, work tables, etc.



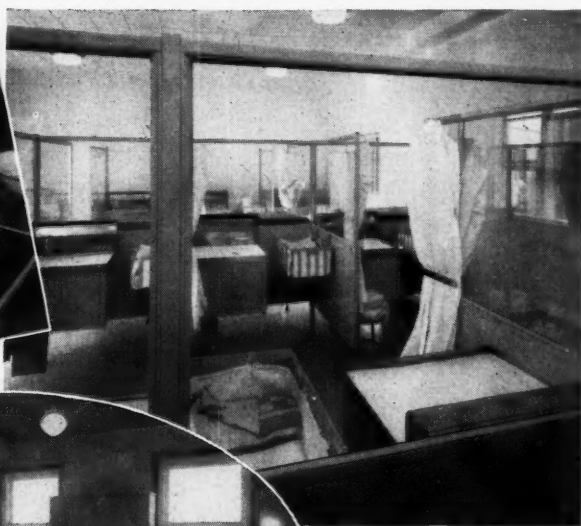
FIRE-SALVAGED EQUIPMENT

"Proved its metal!"

When a disastrous fire swept through the old West Lincoln Memorial Hospital much of the flame-seared equipment was hastily (and roughly) removed . . . Stored in old barns or wherever space was available . . . Eventually being returned to the Metal Craft factory for repairs and refinishing. The fact that over 90% of this old equipment is now again in use in the new hospital is an amazing tribute to its quality construction and craftsmanship. Truly Metal Craft equipment has again "proved its metal" under rigorous service conditions!

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HOSPITAL EQUIPMENT



A view of the Nursery photographed through the plate glass panels which form the nursery cubicles. Partitions, cribs, bath-tables, etc., made by Metal Craft.

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Notes on Federal Grants

Construction

The federal government has allotted \$35,000 for construction projects in Saskatchewan. St. Paul's Hospital, Saskatoon, which is increasing its capacity by 38 beds, is to receive a grant of \$20,000. The sum of \$15,000 has been earmarked for the new 15-bed hospital at Maidstone.

Hospitals in Manitoba have been allotted \$80,000 more from the federal construction grants. A 30-bed hospital being built at Swan River is to receive \$33,000, a 19-bed hospital at Roblin, \$19,000, and a 10-bed hospital at Whitemouth, \$11,300. An 8-bed nursing unit at McCreary has been allotted \$11,300 towards its building costs; and a 6-bed unit at Baldur, \$7,000.

Mental Health

Funds have been set aside for the purchase of an electroencephalograph for the Victoria Hospital, London, and for the purchase of electroshock equipment to be used by the psychiatry department at Queen's University, Kingston, and by the Kingston General Hospital. A federal grant has been made for visual aid equipment to assist teaching programs in mental health at Queen's University and at the Toronto Psychiatric Hospital. Federal funds will also pay the salaries of four additional social workers for the Toronto Psychiatric Hospital.

Money has been allotted for the equipping of a classroom at the Ontario Hospital, St. Thomas, for the use of student nurses taking part of their training at that institution. A grant has been made for the purchase of occupational therapy equipment for the mental hospitals at St. John's, Newfoundland, and at Ponoka, Alberta.

More extensive mental health services are planned for the Niagara Peninsula, with the authorization of salaries from federal funds for a full-time psychologist and a full-time psychiatric social worker to assist the psychiatrist at present holding mental

health clinics in the general hospitals in St. Catharines, Welland, and Niagara Falls.

Personnel

The federal government has allotted \$28,600 in British Columbia to help further the program for training clinical psychologists. The money is being used to provide additional staff for the psychology section of the University of British Columbia, and to buy books, films, and teaching equipment needed to expand facilities for post-graduate training in clinical psychology.

Fifteen Newfoundlanders have been awarded federal assistance totalling \$18,600. Four nurses are to take courses at the University of Toronto; one is to study nursing administration and education; a second will specialize in surgical supervision; a third will study nursing instruction; and a fourth will take a course in medical supervision. All will return to posts at the General Hospital, St. John's. (Five additional nurses will take post-graduate training in public health.)

Of the three other women receiving financial assistance, one will study psychiatric nursing, another will take psychiatric social work, and a third will take post-graduate studies in social work.

Three grants have been made to Newfoundland doctors: one will take a year's course in public health at the University of Toronto; a second will take a three-year course in internal medicine at the Mayo Foundation; and a third will take a year's post-graduate work in thoracic surgery at the Muirdale Sanatorium, Milwaukee, Wis.

The federal government plans to finance four junior fellowships in psychiatry at the University of Western Ontario, London. Funds have also been earmarked to meet the salary of a part-time clinical instructor in psychiatry at the Victoria Hospital in London.

The federal government has

awarded three bursaries in Ontario to assist workers in post-graduate mental health studies. One student will take a short course in the United States; a second will be provided with a travelling scholarship in clinical psychology; and a third will take a year's training in child psychology.

Public Health

Approximately \$32,000 has been earmarked for public health projects in Newfoundland. The new thoracic surgery unit will receive \$29,000. About \$10,000 will be used to purchase equipment, and the remainder to pay the salaries of staff. The sum of \$3,000 has been allotted for the purchase of scientific equipment for a new pathology laboratory at St. John's General Hospital.

Both Edmonton and Calgary are to receive grants to help them increase their public health services. Edmonton will receive \$4,700, which will be expended to buy dental equipment and instruments, and a film projector for health education. Dental equipment, a dental x-ray machine, and health education equipment, are among the items to be purchased by Calgary with its grant of \$5,800.

Federal funds have been set aside to provide new equipment for the division of hospitals and medical services of the Alberta health department to facilitate preparation of statistical data.

In Ontario federal funds will provide the salary for an additional public health nurse for the Welland and District health unit, for a part-time doctor for the health unit of Prince Edward county, for an extra nurse for the Brant county health unit, and for two public health nurses for the division of tuberculosis control of the Toronto City Health Department. The salary for an additional nurse for Dufferin county health unit has been authorized. She will continue an epidemiological survey in connection with poliomyelitis which has been started in the district. Veterinarians are to be added to the staffs of the health units in Northumberland-Durham and in Huron counties.

Health is the thing that makes you feel that now is the best time of the year.—Franklin P. Adams.

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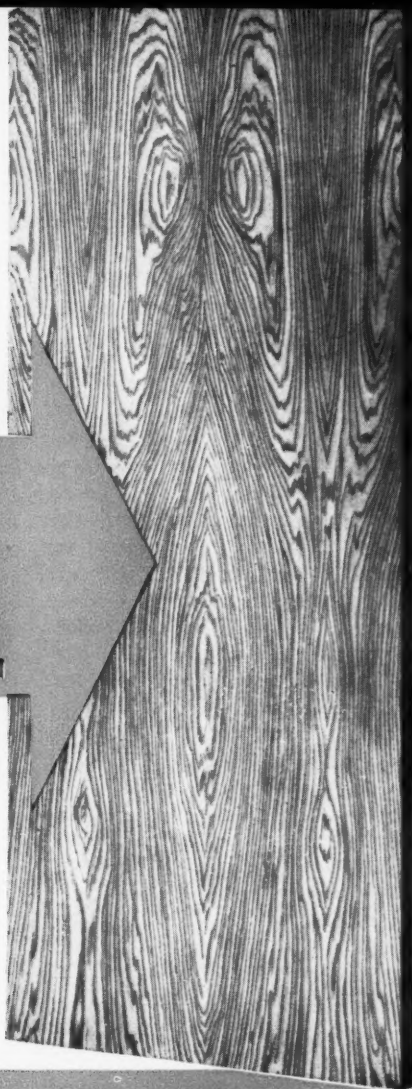
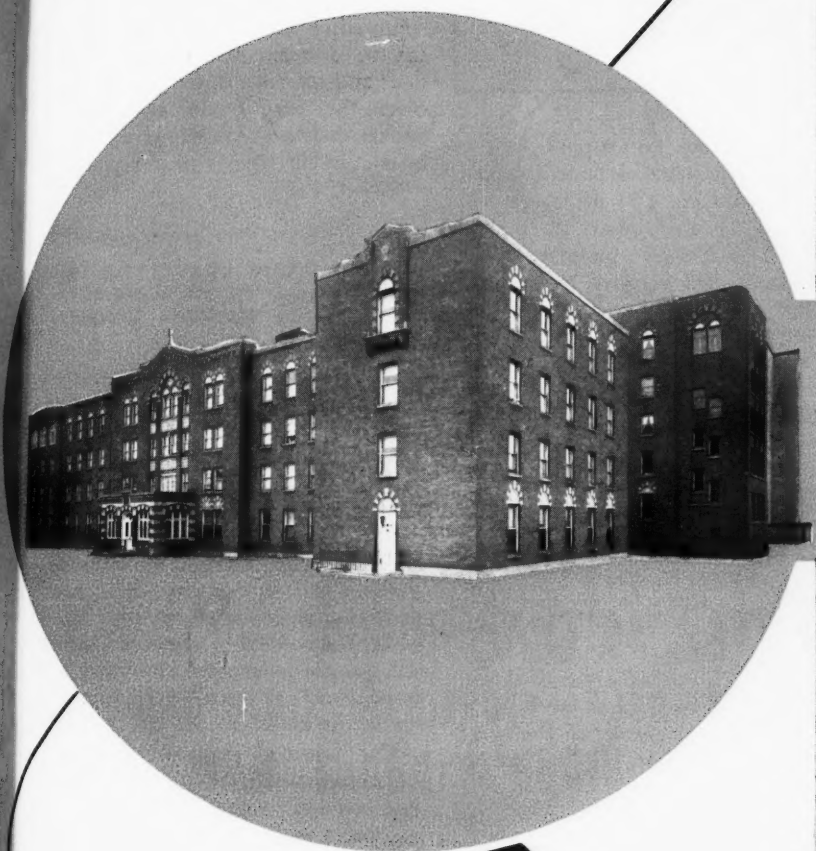
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Hospital Door; 1 3/4" thick. Half round cut veneer, matched grain according to design and colour. Made of Birch — Oak — Ash — Elm veneer. Guaranteed for a period of three years.

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Hospital Door; 1 3/4" thick. Birch only, rotary cut veneer, selected one-piece face. Guaranteed for a period of three years.

Designed along good modern lines and especially constructed to meet the requirements of an interior hospital door. The stiles are 4 1/2" wide, reinforced to 7 1/2" to provide for the installation of push plates and lock assembly. The bottom, centre and top rails are 9" high to provide for "Kick-Plates", "Door Holders" and "Tray Hook".

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Pictured above is the new addition to St. Joseph's Hospital, Toronto, Ont., operated by the Sisters of St. Joseph.

Architects — Marani & Morris, Toronto, Ont.
General Contractors — Pigott Construction Company Ltd.
Toronto, Ont.

◀ Book Reviews ▶

TOM CULLEN OF BALTIMORE. By Judith Robinson. Pp. 435. Price \$3.50. Illustrated. Published by Oxford University Press, Toronto. 1949.

No hospital on this continent has had its early history and that of its pioneering leaders so well recorded and by so many writers as has Johns Hopkins Hospital of Baltimore. Osler, the great internist of the original quartet, besides being one of the greatest medical scholars of all time has had more essays written about him and probably more reading clubs named after him than any other physician on this continent. The Flexners' delightful life of "Popsy" Welch, Hopkins' great pathologist and first dean of the medical school, gave us a vivid picture of the "heroic age" of American medicine and Bernheim's frank and revealing story of his many years under and in succession to the originals adds wonderfully to the picture.

Now we have Judith Robinson's story of Dr. Thomas S. Cullen, the great gynaecologist of that hospital and university. To Canadian readers the story will be doubly interesting for Tom Cullen, like Osler, his own classmate Lewellys Barker, and many others at Hopkins, was Canadian born and educated. He is still a frequent visitor to Toronto where his sister (Mrs. R. A. Daly) lives. Born in 1868 in the parsonage at Bridgewater, Ontario, he took his medical degree at Toronto in 1890, interned at the old Toronto General under Dr. Charles O'Reilly and then went on to Baltimore, inspired by the work of the still young Howard A. Kelly.

This is a delightful and very human story. Tom Cullen had a hard struggle as a youth, as did his unusual parents, undergoing hardships practically unknown to students today. Every week-day morning the young medical student had to get up at half past three to get down to the old *Mail* by four o'clock to collect his delivery route papers. Another early starter passing at that unearthly hour roused him by pulling a string attached to his arm and dangling out the window. Yet he topped his class.

His arduous but happy years in residence at Johns Hopkins Hospital, his fruitful years in pathology with Welch, his early years in practice and as an associate in gynaecology, led to the full years of his maturity when his technical skill, his writings and, above all, his warm and colourful personality added so much to the lustre of this already renowned institution. "T.S." or "Uncle Tom", as he was affectionately known to staff and students, took a keen interest in the welfare of his juniors and the book abounds with instances of his sympathetic encouragement. "I've never wanted to teach my men anything. I've just tried to show them how to find things out . . . Get men thinking and they will teach themselves . . . And never talk down." And "T.S." has taught every one of the fifty-one classes which have graduated from Johns Hopkins medical school.

A revealing sidelight on his tenacity when working in a good cause or for a friend is manifest in his support of the work of the famous Max Brödel who was the father of medical illustration on this continent and probably the greatest medical illustrator of all time. Brought over from Hamburg in 1894, Brödel became world famous for his illustrations of Dr. Kelly's great work. In 1910 it looked as though it might be necessary to let him go to the Mayos but Cullen, by persevering personal effort, finally succeeded in obtaining funds sufficient to launch and, later, endow a Department of Art as Applied to Medicine with Max Brödel as its head. Years later, when Tom Cullen was seventy and nearly five hundred of his friends gathered to honour him at a dinner, it was Max Brödel who expressed the sentiments of all when he rose to speak. Leaning down to kiss T.S.'s bald spot, he said, "The best of Tom Cullen is his warm and generous heart."

Judith Robinson is to be congratulated on the fine quality of her writing. Canadians have known her mostly as an able controversial writer with a rare and deadly ability to

with her adversaries. We now realize that she can be tender and appreciative as well as devastating; can be dramatic without exaggeration; and can portray the figures that cross the pages with such vivid strokes that they veritably step out to become living friends of the reader. —G.H.A.

THE INNOCENT TRAVELLER. By Ethel Wilson. Pp. 276. Price \$2.75. Published by MacMillan Company, Toronto. 1949.

We welcome a second novel by Mrs. Wilson whose *Hetty Dorval* won acclaim in 1947. This new book is a second family chronicle, having as its dominating character the delightful Topaz who chatted incessantly for over 97 years. The story is part true and part fiction, we are told, and one gathers that much of it has been gleaned from Topaz's voluminous correspondence. She had sisters and cousins "whom she numbered by the dozens" and not a detail concerning any of them escaped her.

The opening chapters sketch a slightly sardonic picture of Victorian England and succeeding pages reveal a true kaleidoscopic view of the young city, Vancouver. Topaz, dressed in an enveloping bathing costume heavy enough to sink any marine animal, presents a whimsical picture as she pushes her cumbrous English bicycle along the beach. We doubt whether she ever learned to swim, but she had fun anyway—there was a male swimming instructor, which wasn't quite, quite. . . .

Written in lucid, succinct prose, this book portrays a period, in fact a century, when there were more social restraints than we know today—and just possibly those who set the pace were not entirely wrong. The highest tribute we can pay to *The Innocent Traveller* is to relate that a very intelligent person of some 80 years read it all within 24 hours and finished quite confused between laughter and tears. She noted it in her diary as one of her *favourite books*.

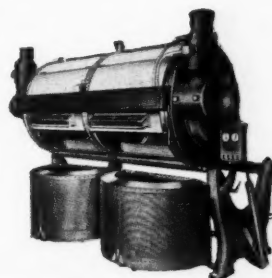
As most readers in the hospital field will know, the author is the wife of Wallace Wilson, M.D., Vancouver, a past president of The Canadian Medical Association. If at this date

(Concluded on page 76)



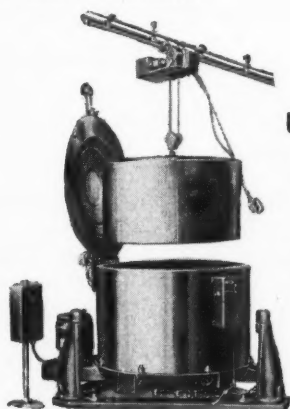
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Hospital Decentralization Imperative in Canada's Health Defences

ADEQUATE facilities to handle war casualties do not exist in any city in Canada. This was the opinion expressed by Major-General F. F. Worthington, Co-ordinator of Civil Defence, at the annual meeting of the Defence Medical Association of Canada in Toronto last month.

If we become involved in another war, we shall probably have greater numbers of casualties than ever before. Therefore we must be prepared. Fire has been one of the chief killers in time of war. Some 83,000 people lost their lives in one fire in Tokyo during World War II. Canadian cities are not as vulnerable as Japanese cities, from the point of view of fire, but they are more so than those in Europe.

Preparations for defence must be co-ordinated from the top down. There must be casualty clearing stations and surgical teams to staff them. It is also essential that adequate hospital facilities be available. It will be important to segregate the patients who have been subject to radioactive contamination. Teaching defence methods to the civilian doctor, who is without a background of military experience, will be another major task.

The present tendency to centralize hospital facilities could have serious consequences, stated General Worthington. In some of our large cities most of the hospital facilities and available hospital equipment might be wiped out in a matter of seconds, and, at the same time, most of the nurses and doctors. At Hiroshima only 9 out of 200 doctors were left and less than 100 out of some 1,700 nurses. Actually most of the deaths in that city were due to consequent lack of attention.

New hospital buildings should be well scattered and remote from other likely targets. In time of emergency extra beds and temporary accommodation would undoubtedly be required.

In case of major attack it would probably be necessary to treat large

numbers for flash burns, varying degrees of radiation, et cetera. Not only might a whole population need some measure of treatment but probably the livestock as well. Extensive inoculation might be necessary, as in the Services. Sanitary control is important and, of course, the water supply would need to be protected.

All or part of the population might have to be evacuated, while it would be necessary to stockpile essential medical supplies. The Red Cross and the St. John's Ambulance organizations would be vital links.

"Psychological first aid" would be essential for, during air raids, many people become emotionally upset without any physical injury. The Allan Memorial Institute in Montreal is now making a serious study of this aspect of the problem. Panic can be very serious. Fear of the unknown is best combatted by letting people know the extent of the danger and what they can do to meet the situation.

It is essential to keep in mind the possibility of chemical and bacterial warfare and the necessity of training the civilian medical profession to cope with such situations. At the same time increased recruitment for the medical and nursing professions would be of prime importance.

New X-Ray Unit Designed

Two new light-weight x-ray units have been designed for use under strenuous military conditions. The machines are identical except that one is made primarily of steel and the other of aluminum. Units are being made of each of these metals so that, if there were a shortage of one metal, the other could be used.

Both the units are lighter than the ordinary x-ray machine which weighs approximately 3,000 pounds. The steel unit weighs 2,100 pounds, and the aluminum one about 1,600 pounds. The units

may be easily serviced, assembled, or dismantled. They break down into sub-assemblies each of which weighs less than 200 pounds. Even the transformer is a single simplified package although it is capable of carrying 100 milliamperes of direct current and of supplying 100,000 volts. The machine is equipped with a "reciprocating Bucky diaphragm" previously unavailable for military field use, and with a spot-film device which makes it possible to snap x-ray pictures through the fluoroscope.

During transport, the machine is shock-mounted in a special watertight, rigid, corrugated metal container weighing about 700 pounds, which is sufficiently buoyant to float.

Ontario Conference, C.H.A. Holds Annual Meeting

At the close of the Ontario Hospital Association's jubilee convention, delegates to the Ontario Conference of the Catholic Hospital Association met at St. Joseph's Hospital, Toronto, to take part in their 16th annual meeting.

The first day, November 2, was devoted chiefly to a business session and the president's address. On the second day, among the speakers were J. J. Geoghegan, M.D., whose topic was the psychiatry department in the general hospital, Ocean G. Smith, who discussed hospital accounting, and Miss Muriel Jean Westney, "Cafeteria Service".

The following were elected as officers for the coming year:

President: Sr. M. Ursula, Hamilton

1st Vice-pres.: Sr. M. Gonzaga, Peterborough

2nd Vice-pres.: Sr. Joseph Edmund, Ottawa

3rd Vice-pres.: Sr. Evangeline, Pembroke

Sec.-treas.: Sr. Murphy, Kingston

The art of living does not consist in preserving and clinging to a particular mood of happiness, but in allowing happiness to change its form without being disappointed by the change; for happiness, like a child, must be allowed to grow up.—Charles Langbridge Morgan.

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| INSTEAD OF | INSTEAD OF | INSTEAD OF | INSTEAD OF |
| Mayo Intestinal #1, #2 Murphy Intestinal #1, #2 Ferguson #6, #8 Mayo Catgut #1, #2 | Mayo Intestinal #3, #4 Murphy Intestinal #3, #4 Ferguson #10, #12 Mayo Catgut #3, #4 | Regular Surgeon's #2, #3 Fistula #2, #3 Mayo Trocar #2 Martin's Uterine #4 | Regular Surgeon's #4, #5 Fistula #4, #5 Mayo Trocar #3, #4 Martin's Uterine #5, #6 |
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It pays to standardize on Ethicon Atralog (Eyeless) Needle Sutures.



◀ Provincial Notes ▶

British Columbia

CRESTON. A new 40-bed hospital in the shape of a cross is to be built at Creston. The western section will contain the administration offices; the northern will accommodate the maternity wards and the operating theatre; the southern portion, the kitchen, utility rooms, and wards; and the eastern, the semi-private and isolation rooms.

Saskatchewan

BIRCH HILLS. Proposed construction of a 15-bed union hospital at Birch Hills has been approved by the Saskatchewan Planning Commission. The cost of the building plus equipment is estimated at \$100,000.

* * * *

INDIAN HEAD. A 27-bed hospital is to be built at Indian Head to replace the present outdated structure. The hospital, L-shaped and only two storeys in height, will be of fire-resistant construction. It has been designed by Portnall and Stock, Regina.

* * * *

NEILBURG. A new union hospital has been officially opened at Neilburg. With a capacity of ten beds and minor operating room facilities, the structure was erected at a cost of \$40,000. Mrs. K. Shattuck will be matron of the hospital.

Manitoba

GLADSTONE. A district hospital with a capacity of 16 beds and 9 bassinets is to be erected in Gladstone. It will contain minor surgery, x-ray, and laboratory departments, and a room for medical health and public welfare services.

SOURIS. The District Hospital Board, at Souris, has decided to enlarge and renovate the present hospital rather than to erect a new one. They plan to build two single-storey wings at a cost of \$90,000 and to remodel the present building at a cost of \$20,000. The wards will occupy the new wings, with other services in the centre building.

* * * *

SWAN RIVER. A new district hospital is being erected at the village of Swan River. It will contain 30 beds, an 11-cubicle nursery, operating rooms, x-ray and laboratory facilities, and offices for the local health unit.

* * * *

WINNIPEG. Work will soon begin on a 6-storey addition to the Victoria Hospital. The new structure will contain 96 beds and an operating floor and is expected to cost between \$300,000 and \$400,000. The old nurses' residence is to be demolished to make room for the addition.

Ontario

BANCROFT. The Red Cross has officially opened the 22-bed hospital at Bancroft which replaces an old 8-bed institution. The building is 2 storeys high with a centre section of field stone and 2 wings of frame. Wards are located in the wings, and the offices, kitchen, and nurses' quarters are in the central part of the building. It was built at a cost of \$200,000.

* * * *

GRIMSBY. The new West Lincoln Memorial Hospital has been officially opened. The \$270,000 hospital contains 32 beds and 14 bassinets. It is Y-shaped, one storey high, and has facilities for major and minor operations. Hospital plans call for a 100-bed institution and it is planned to increase the hospital to this size.

HAMILTON. Construction of a 100-bed maternity wing for St. Joseph's Hospital will begin shortly. The new wing, which will cost approximately \$500,000, will be L-shaped and 4 storeys in height.

* * * *

LONDON. A \$600,000 residence to house 265 nurses at the Westminster Hospital is nearing completion. The building contains private rooms for all the nurses, recreation rooms, gymnasium, and a swimming pool.

* * * *

MARKDALE. The Centre Grey Public Hospital, Markdale, has been officially opened. This institution, which was operated for many years as a private hospital, has been renovated and enlarged at a cost of approximately \$80,000. It will accommodate between 25 and 30 patients and contains a 10-bassinet nursery, a delivery room, and an operating room. The superintendent is Miss Isabel Boyd, Reg.N.

* * * *

PEMBROKE. The major operating-room of the Pembroke General Hospital has been newly equipped in memory of Dr. John B. Galligan, one of its physicians. An operating table, a surgical light, and various steel accessories were donated by the doctors, the Knights of Columbus, and by friends of Dr. Galligan.

* * * *

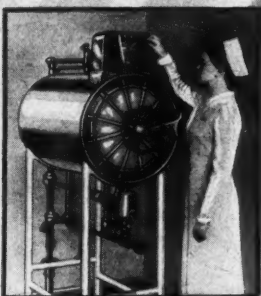
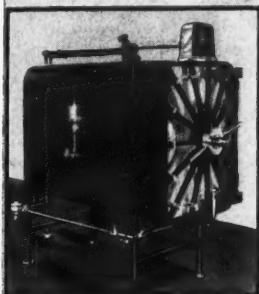
TORONTO. The cornerstone of a new \$1,500,000 wing for the Toronto East General Hospital has been laid. The 7-storey addition, which is to be known as the Joseph H. Harris Pavilion, will accommodate 210 patients and will contain new operating rooms and large children's nurseries.

* * * *

TORONTO. A new \$2,000,000 wing has been opened at the St. Joseph's Hospital. The addition, known as the Morrow Memorial Wing, increases the hospital's capacity from 350 to approximately 600 beds. A maternity ward with a bed capacity

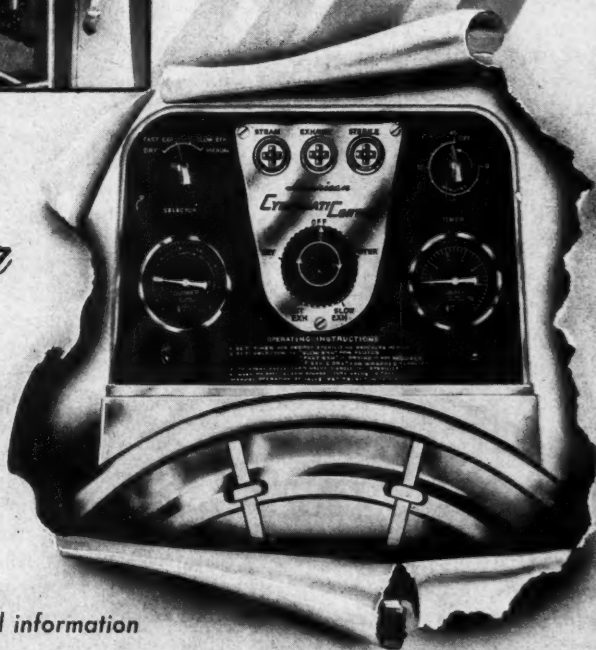
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With the Hospitals in Britain

By "Londoner"



C. E. A. Bedwell

Dear Mr. Editor:

The editorial discussion of "What is a public ward?", which appeared in your September issue, suggests that it may be of interest to give some par-

ticulars bearing on the subject under the new legislation in this country.

The National Health Service Act approaches it from a rather different angle. S. 4 states that "where there is provided in any hospital, as part of the hospital and specialist services, accommodation in single rooms or small wards, the Minister may make any such accommodation, which is not for the time being needed by any patient on medical grounds, available for patients who undertake, or in respect of whom an undertaking is given, to pay for the accommodation such charges, designed to cover part of the costs thereof as may be determined in the prescribed manner, and the Minister may recover those charges." The object of this section is to give the general patient, when his condition requires it, access to the secluded accommodation.

It may also be argued that it gives a sick man urgently requiring attention priority over the man of means who only requires rest and quiet under observation because of business worries. So far there has not been much movement to apply this section on any extensive scale; but the time may well come when the many problems suggested by it will cause a good deal of difficulty for administrators. In fact it raises the whole question of whether there should be any special type of accommodation to which the primary means of access is a monetary payment. Most medical men would agree that many of the patients who desire a room to themselves would be much better in an open ward with a number of other patients.

Another point to be noticed in this section is that it authorizes a charge to be made which covers only part of

the cost. In the next section authority is given to continue the provision of private patient accommodation where the patient is liable for the whole cost "including an appropriate amount in respect to overhead charges". In addition the patient is liable for the cost of any services rendered by the medical practitioner attendant upon him. This section also contains the proviso giving priority to a patient upon medical grounds. The phrase "private patient" is not defined in the Act but Mr. S. R. Speller in his annotated edition of the

Room Priority on Medical Grounds

Act considers that it doubtless bears "the ordinary meaning, namely, a patient who is utilizing the services of the particular medical practitioner under a private arrangement as to remuneration and not under the provisions of the Act."

The details of the charges authorized by the Minister being in English values do not need recapitulation here. It is sufficient to note that the maximum total allowed for medical services is £75. It is also worthy of notice that not more than 15 per cent of the total accommodation of the hospital may be given up to private patients. Similar arrangements are in operation for out-patients to be seen privately in accommodation made available by the hospital. This provides an official cloak for a practice which has existed for many years especially in hospitals with medical schools. It is specially workable in hospitals with the appointment system. It is quite possible for an appointment to be arranged only after an interval of three or four weeks. The patient has been told by his doctor that the matter is urgent and so

is offered, for a fee, an appointment as a private patient because this can be arranged in a day or two.

Immediately bearing upon the points raised in your editorial is a note that "wards divided into cubicles by curtains will normally fall into the category of wards with more than two beds". There is no attempt to define small wards. It is generally understood, however, that single rooms, two-bed and four-bed rooms are regarded as private accommodation. Surely "private" in that connection derives its origin from comparison with the open ward of twenty or more patients. A two-bed room provides privacy and company which many people like, while a single room combines privacy with loneliness.

Some efforts have been made by the Ministry to secure a wider distribution of private patient accommodation of the type in which only part payment of the cost is made. There is, however, a natural tendency under the present financial stringency not to launch out too greatly in this direction as the number of patients who have the means to provide themselves with special accommodation is steadily diminishing. The time is coming when a patient will be a patient whatever his social circumstances and already the marked distinctions which used to exist between one section of the community and another are not so evident, especially when they are in hospital.

D. M. Cox Addresses Montana Association

Donald M. Cox, secretary and manager of the Winnipeg Municipal Hospitals and president of the Upper Midwest Hospital Association, was a guest speaker at the annual meeting of the Montana Hospital Association which was held in Great Falls on October 14 and 15. He addressed the gathering on "Hospital Needs of the Community" and reported on the Upper Midwest Hospital Association.



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Correspondence

The General Practitioner

To the Editor:

I have read with great interest Mr. C. E. A. Bedwell's article, *Rightful Place of General Practice*, which appeared in your November issue under your regular section, "With the Hospitals in Britain".

As a transatlantic observer of the operation of National Health Services, it is my view that Mr. Bedwell has highlighted the fundamental weakness of the whole plan, the virtual exclusion of general practitioners from hospitals. He refers to the lip service given to the importance of the general practitioner, a custom which is not unknown in this country, and one which must be justified by appropriate action when the general practitioner's status is threatened.

Mr. Bedwell quotes *The Times* as stating, "The health service which was to have effected the renaissance of general practice may well carry its deterioration still further . . . No hospital or specialist service, however elaborate, can offset defective treatment in home or surgery." I could not agree more wholeheartedly with these opinions, and I would like to cap the quotation with another from a recent review of the first year under National Health Services published in a special issue of *The Practitioner* in which a country doctor summarizes the situation in these words: "A magnificent opportunity of raising the whole standard of country practice has been thrown away owing to the ignorance of country practice of Regional Hospital Boards, and the belief that progress depends on making all hospitals conform to one type"; and again quoting a Scottish practitioner, "There is an unhappy feeling abroad that the general practitioner is being debased in status from a professional man to a tradesman."

These are serious words which we would do well to heed. Fortunately there is evidence that in Great Britain the authorities are beginning to recognize that the exclusion of the general practitioner has gone too far, as a circular issued in the month of Octo-

ber by the Ministry of Health enjoins Regional Hospital Boards not to close entirely the door of cottage hospitals to local practitioners.

What is good for the country doctor is equally good for his urban counterpart. Until that distant day, mentioned by Mr. Bedwell in his concluding paragraph, when the preventive services will have reduced our need for hospital beds, let us hold fast to the principle that good medical care is promoted by a partnership between hospitals and all members of the medical profession.

Yours sincerely,

"A. D. Kelly",

Assistant Secretary,
Canadian Medical Association.

R. H. MacDonald, M.D., C.M.

Dr. R. H. MacDonald, chief of staff of St. Paul's Hospital, Saskatoon, Sask., died suddenly as the result of an acute coronary occlusion on October 15, 1949, while attending a meeting of the International College of Surgeons in New Orleans.

Born at North Bedeque, Prince Edward Island, Dr. MacDonald received his medical degree with honours from McGill University in 1908. Serving his internship and residency in Bellevue Hospital, New York, he went to Saskatoon in 1913 to join the late Dr. H. E. Munroe. Upon the outbreak of World War I, he joined the C.A. M.C., serving with such distinction that he was decorated with the Military Cross and the Distinguished Service Order.

Among his many appointments he had been consulting chest surgeon to the Anti-Tuberculosis League in Saskatchewan, consulting surgeon to the Cancer Commission Clinic in Saskatoon, and regional surgeon of the Canadian Pacific Railways. In 1920 he was elected a Fellow of the American College of Surgeons and in 1931 became a chartered Fellow of the Royal College of Surgeons (Can.).

An ardent student of world history and of genetics, he had also won international repute for his fox and mink breeding. •

Medical Record Librarians Hold 15th Convention

From October 31 to November 2, the Canadian Association of Medical Record Librarians met in convention at the Royal York Hotel, Toronto. Morning and afternoon sessions were devoted to business reports, special addresses, discussion periods, and a round table conference with the Ontario Hospital Association.

Appearing on the slate of guest speakers, Sister Celine, Toronto, chose as her topic, "The Medical Record Librarian Looks at Herself", and Miss Rita Redmond, London, addressed her remarks to those desiring to organize a provincial association. Speaking on "Medical Ethics", Dr. E. F. Brooks, University of Toronto, stressed the fact that one code of ethics should apply to doctor, nurse, and medical record librarian and that it was their ethical duty to protect the confidences of the patient. Dr. K. G. Gray, also of that University, discussed hospital medical records in Ontario from the viewpoint of (a) when the hospital may be compelled to produce its records, and (b) when a hospital is entitled to produce its records voluntarily. A new feature of the convention—an address in French, "Traitement Chirurgical des Maladies Pulmonaires", by Dr. Georges Deshaies, University of Montreal—received a warm reception by the many French-speaking sisters present.

Officers elected for the coming year include:

President: Genevieve MacDuff, St. Michael's Hospital, Toronto

President-elect: Edith Mortlock, Notre Dame Hospital, Montreal

1st Vice-pres.: Sister Bernice Hughes, Hotel Dieu Hospital, Kingston

2nd Vice-pres.: Laura Larkin, Sunnybrook Hospital, Toronto

Recording Sec.: Gloria Ringham, St. Mary's Hospital, Kitchener

Financial Sec.: Miss L. Johnstone, Hamilton General Hospital, Hamilton

I have seen flowers grow in stony places; and kindness done by men with ugly faces; and the gold cup won by the worst horse at the races, so I trust too.—*John Masefield.*

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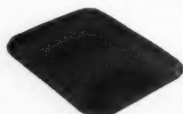


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Hazards of Anaesthesia

Anyone who wishes to give any special type of anaesthesia should be willing to spend two, three or four weeks at some teaching centre where he can obtain competent instruction and practice. There is no place for the self-trained anaesthetist. One would never think of flying an aircraft by merely going to the flying field to watch some one else take it off and land it and be told how it was done. One must take dual instructions until sufficient skill is obtained before going solo. The same should apply to anaesthesia. In this regard I might digress for a moment and tell you what I know of the attitude of both Dr. Smirle Lawson, the Chief Coroner for Ontario, and Mr. Blackwell, the Attorney General, on deaths occurring on the operating room table. I have talked to both of them on this subject. As far as they are concerned, if the anaesthetist has been adequately trained in the type of anaesthesia he was using and was using all precautions ordinarily used in the administration of that particular type of anaesthesia, he will not be held accountable for the patient's death. They realize that there is a certain hazard in all anaesthesias and as people die on the street, in their offices and in bed, they will at times also die on the operating table and if the anaesthetist with adequate training was doing his honest best and understood what he was doing, he has fulfilled his duty to the best of his ability.

On the other hand, the self-taught anaesthetist with no training, who endeavours to use complicated gas machines, administers spinal anaesthetics to obviously poor risks, gives sodium pentothal because he has seen it given, is a menace to society and is judged as such. The trend now seems to be, when a death occurs on the operating table, to determine the training and experience the anaesthetist has had and to endeavour to determine whether or not he was capable of doing, with reasonable safety, what he was attempting at that time.

—Excerpt from an article of the same name by W. Easson Brown, M.D., in Ontario Medical Review, Aug., 1948.

The battle against tuberculosis is not a doctor's affair; it belongs to the entire public. —Osler.

The CANADIAN HOSPITAL

In Praise of Voluntary Groups

I would like to pay tribute to those voluntary, often unpaid, and too frequently unsung, heroes of humanity who are enrolled under the banners of non-official, but extremely effective, organizations, working alongside your governmental officials to ease the lot of the unfortunate and to succour the distressed.

If, already, many objectives have been attained in our co-ordinated assault on disease, distress and destitution, much of the credit goes to the officers and soldiers of those private or charitable groups which have been striving beside the official public health forces, and with their brothers in welfare and social service, to ensure the well-being of Canadians.

Whatever success Canada has achieved in her strivings to improve conditions for her people has been, in large measure, due to the co-operation which has always linked all the agencies enlisted in the fight for higher standards of health and welfare.

As science and social thinking have been invoked and translated into humanitarian action, federal, provincial, and local authorities, have been supported nobly and steadfastly by all our voluntary organizations, for the accomplishment of progressive projects and in the projection of plans for even greater measures of national security.

Pioneering new fields in the fight against sickness and suffering, these voluntary agencies have indeed often inspired the concentration of effort on certain phases of health work. These modern crusaders—these 20th century Samaritans—have been the bulwark of every endeavour to implement our national health and welfare program.

Public health authorities, as well as practitioners in medicine and its allied professions, are fully aware of, and grateful for, the contributions which members of these groups have made to the common welfare, and local officials everywhere will be first to admit that, without their aid, much of our social service work could not be performed so efficiently and effectively that, today, it embraces every needy citizen.—*The Hon. Paul Martin.*

Rest and abstinence are the best of all remedies, and abstinence also cures without danger.—*Celsus.*

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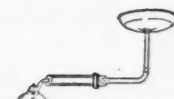
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Rural Hospitals

(Concluded from page 31)

registry in 1944 approximately 308 nurses, in 1945, 264 nurses, and in 1946, 167.

Their report showed a training capacity in existing training schools of 1,043 students, which might be increased by another 75. Only 894 students were in training at that time, 275 would be graduated during 1948, and this number might be slightly increased in 1949 and 1950. In 1944, 348 students applied, 247 were accepted and 238 graduated. In 1945, 367 students applied, and 321 were accepted and 237 graduated. In 1946, 372 students applied, 291 were accepted and 242 graduated. In June, 1946, 1,399 girls were to be graduated from high school grade XI; 620 from grade XII.

The above report of our Committee recommended:

1. To provide for an increase in the number of students in the nurse training schools then existing.
2. To provide for an organized plan to interest young women in the nursing profession.
3. Information to be made available as to assistance for nurses.
4. Study of retirement scheme for nurses urged.

Present Situation

Not much headway having been made and the situation becoming more serious, the Health Commission saw fit to call a special meeting to consider this matter and invited to this meeting the executive of the Manitoba Association of Registered Nurses and the president of the Manitoba Hospital Association, Dr. O. C. Trainor. At this meeting, the Department of Health presented a detailed statement of the nursing situation as it appears today. Figure 1 will show how the shortage of nurses is becoming more serious from day to day.

As a result of these facts, the Health Advisory Commission immediately set up a committee of two members from each of the three organizations, namely, the Commission, the Manitoba Association of Registered Nurses, and the Manitoba Hospital Association, with a chairman, to carry on the work commenced by the previous committee and to endeavour

to find some means by which the present-day needs can be met, as opposed to the long term plan. You will recognize what a task lies before this Committee.

Department of Health Circular

The Deputy Minister of Health recently sent out a circular to all hospital districts drawing attention to the shortage of nurses, and stating that grants would not be available to new hospitals unless assurance be given that they could be properly staffed without depleting existing hospitals. As it will be impossible to staff new hospitals without depleting other staffs, the circular should have so stated.

New schemes are being developed and votes are being taken, apparently without the people being made aware of the true situation. They are going to be much disturbed if they find, on completing their hospital, that they may not be allowed to open due to lack of sufficient nursing staff. I shall mention one instance. In a new district which I visited, a new hospital was nearing completion. It was apparent that all the facts which they should have had before proceeding with their scheme had not been given. The hospital was to open in a few months. When I asked a member of the Board if they had secured a staff for their hospital, he stated that they were not yet open and would not deal with that matter until then. When I expressed doubts that they might be able to get nursing staff, he seemed surprised and asked, if there were any doubts on that score, why they had not been advised of it.

Duty of Association

There is need for this Association to give out the true facts, if those whose responsibility it has been have failed to do so. We have already relied too long on someone else to do this. A fuller realization on the part of the Department of Health of the practical knowledge that has been available through this Association, and more use made of it, would have helped to overcome present-day misunderstandings. It is true that this Association has been represented on the Manitoba Hospital Council, although not on the Health Advisory Commission. Even there, our representatives have not been given the opportunity to utilize their knowledge

of hospitalization to the extent which we anticipated.

Civic Pride or the Patient?

Some districts not so badly in need of hospital facilities have been well equipped, while others facing a great need have no nursing staff available for them. This means an inequitable distribution of the nursing personnel now available. The nurses should have been utilized in the area where the need was greatest and in institutions that could give the greatest amount of service.

What should be our first concern? To consider the wishes of people in rural areas, based on civic pride? To consider the welfare of the doctor in outlying districts? Or should the *patient* be our chief concern? I have no hesitation in saying that the patient should be our chief concern. It is for him or her that this *health scheme* has been proposed, and I am afraid we are leaving the patient in the background. Fine buildings and medical units in every hamlet will not guarantee to the patient the service he needs. We can provide the finest buildings and equipment possible, but if there are not sufficient capable doctors and nurses to staff those buildings, our endeavours are worthless. We cannot risk permitting surgery, even with the most capable doctors, if we cannot guarantee to the patient that a competent nursing staff is available to him or her after the operation.

The provision of facilities for proper diagnosis is another service essential to the welfare of the patient. This cannot be provided in every small unit wherein the number of patients cannot justify such an expenditure. This means that we must first concentrate our attention on the development of general hospitals where all of these facilities can be provided, where more than one doctor is available, and where our few nurses can serve more patients more effectively. Only when this has been accomplished can we devote our attention to determining what auxiliary services are necessary in outlying districts, services which are dependent upon the staff that can be made available for them. We are moving too fast in one direction, namely, the building of hospitals, without realizing that the provision and training of staff are not keeping pace with it. ●

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DECEMBER, 1949

25 Years Ago

December, 1924

The new Psychiatric Hospital in Toronto had been completed. This hospital would permit the early examination and care of psychoses without requiring that the patients go through the tedious details of being admitted to a mental institution.

A new \$1,500,000 children's hospital was being planned for Montreal. The capacity of the existing Children's Memorial Hospital was 96 beds.

The Memorial Hospital, St. Thomas, Ontario, had just been opened. The hospital was a three-storey building containing 38 rooms for patients and 4 public wards.

The new \$800,000 provincial mental hospital at Essondale, British Columbia, was completed. Dr.

H. C. Steeves was superintendent of the hospital, with Dr. A. L. Crease as one of his associates.

A new hospital at Estevan, Saskatchewan, was officially opened. The building, formerly a theatre, was converted and remodelled to make a 30-bed hospital.

Construction work on a new wing for the Yarmouth Hospital, Yarmouth, N.S., was begun. The two-storey building was designed to contain 7 rooms for patients, as well as an 8-bed ward.

A.H.A. Plans 21 Institutes for 1950

The American Hospital Association's Council on Education has announced plans for 21 institutes in 1950. For the first time, the association will conduct a series of 9 two-day institutes in conjunction with meetings of state and regional hospital associations. Three of these two-day institutes will be on accounting, two on public relations, two on purchasing, one on personnel, and one on dietetics.


Subjects to be covered in the 12 five-day institutes are hospital establishment, engineering, nurse anaesthetists, accounting, pharmacy, laundry, personnel, purchasing, medical records, housekeeping, dietetics, and planning. The first institute for 1950, which will be held in Chicago at the Edgewater Beach Hotel, from January 16 to 20, will be on the subject of hospital establishment.

U.S.A. Veterans' Hospital Building Program May Be Restored

The House Veterans Committee has voted to force President Truman to restore the 16,000-bed cut in proposed veterans' hospital construction.

Last January Mr. Truman cancelled \$237,000,000 of contract authority voted by Congress for additional hospital facilities. This meant the cancellation of plans for 24 new hospitals and reductions in the size of 14 others.

There has been wide criticism of the Veterans Administration for over-building, many of their present beds not being occupied. It has been said that over-building of veterans' beds would pave the way for widespread extension of state medicine.



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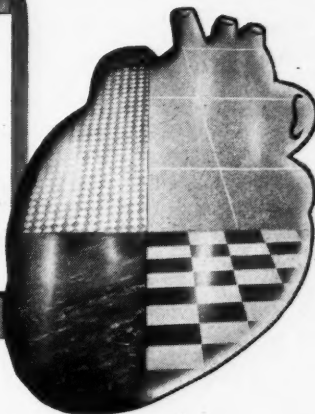
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Alberta Conference, C.H.A., Meets in Calgary

The Annual Convention of the Catholic Hospital Conference of Alberta was held in Calgary on October 31 and November 1, immediately preceding the convention of the Associated Hospitals of Alberta. Delegates from all the Catholic hospitals in the province were present. Guest speakers at the convention included Rev. John J. Flanagan, S.J., St. Louis, Executive Secretary of the Catholic Hospital Association, and Rev. H. L. Bertrand, S.J., Montreal, President of the Catholic Hospital Council of Canada.

The following officers were elected for the coming year:

President: Sister F. Keegan, Edmonton

1st Vice-pres.: Sister Beatrice, Banff

2nd Vice-pres.: Sister St. Alban, Edmonton

Sec.-treas.: Sister M. Joanna, Edmonton.

C.S.R.T. Officers for 1950

The Canadian Society of Radiological Technicians has elected the

following officers for the coming year:

Hon. President: J. F. C. Anderson, M.D., Saskatoon, Sask.

President: H. M. Welch, Calgary, Alta.

Vice-pres.: A. Perry, Bridgewater, N.S.

Sec.-treas.: W. Q. Stirling, Vancouver, B.C.

Among those who will serve on the Board of Directors are Dr. E. A. Petrie of Saint John, N.B., Canadian Medical Association appointee, and Dr. F. G. Stuart of Winnipeg, representing the Canadian Association of Radiologists. The President of the C.M.A. is automatically appointed honorary president of this society.

Report of C.H.C. Pension Committee

The report of the Committee on Pensions, Canadian Hospital Council, presented at the Biennial Meeting in Quebec, has recently been published as Bulletin No. 51 and distributed to hospital superintendents and chairmen of boards of trustees. There are still a limited

number of these bulletins on hand and they are available to anyone who did not receive one or to those desiring extra copies. They may be obtained by writing to the Canadian Hospital Council, 280 Bloor Street West, Toronto.

Mary Macbeth Joins Federal Nutrition Division

The Department of National Health and Welfare at Ottawa has announced the appointment of Miss Mary Macbeth to the post of chief nutritionist in the nutrition division of that department. Under the direction of the chief of the division, Dr. L. B. Pett, she will be responsible for nutritional surveys, service to institutions, and contacts with professional groups. A graduate of the University of Alberta, Miss Macbeth continued her studies at Oxford University on a British Council scholarship, and received the highly-prized B. Litt. degree for her work on the history of special nutritional programs for vulnerable groups in the United Kingdom.

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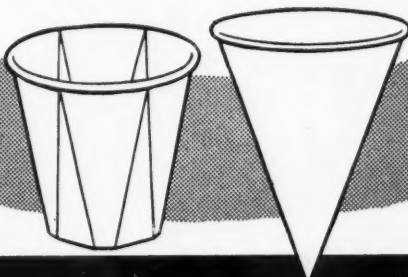
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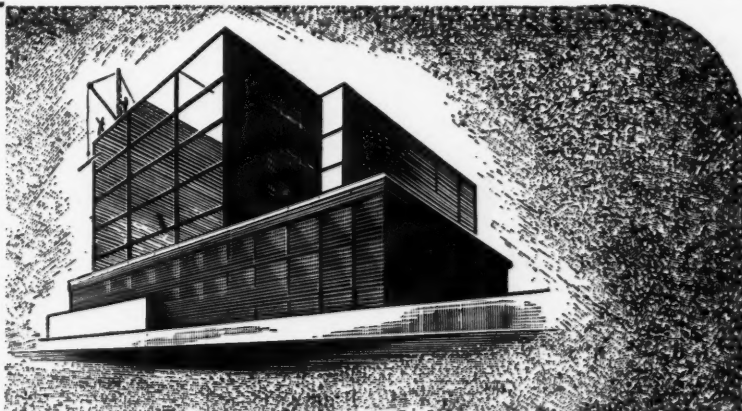
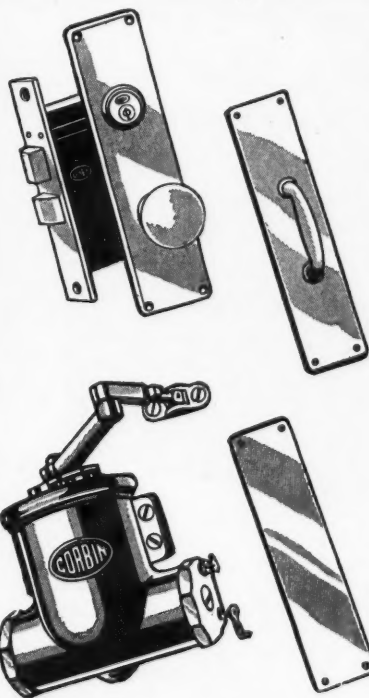
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Exhibitors Sponsor Variety Show

On November 1st, after the O.H.A. Jubilee Banquet, delegates were guests at a concert sponsored by the exhibitors. This welcome and delightful entertainment included dance and song routines, an unusual performance of bell ringing, and an exhibition of clever drawing by the cartoonist, Lou Skuce of Toronto. During the evening, Miss Pearl Morrison, retiring president of the O.H.A., was the happy recipient of a mantel radio presented by Edwin J. Turner, chairman of the program committee.

B.C. Survey

(Continued from page 44)

It was also recommended that the government implement a system of housekeeper care for patients who can be kept at home.

Nurse Shortage

The current shortage of graduate nurses could be overcome, the report stated, only by immediately increasing the number graduating each year from 463, the 1949 figure,

to 600. In addition, the number of practical nurses being graduated, which totalled only 35 in 1949, should be raised to 200 each year, and the number of mental hospital nurses raised from 140 to 200 each year.

Training Course for Hospital Administrators

It was recommended that a course for the training of hospital administrators be established and conducted by the University of British Columbia in conjunction with hospitals in Vancouver, Victoria, and New Westminster.

Dental College

With the establishment of a medical faculty at the University of British Columbia, it was recommended that a correlated dental college be set up.

Tribute to Country Doctor

The people of Oungre, Saskatchewan, and the surrounding district have erected a memorial to Dr. James Brown as a tribute to the country doctor who looked

after them for 30 years. The memorial itself is a band-stand which was constructed at a cost of approximately \$1,000 and bears the inscription "To the glory of God and in loving memory of James Brown, M.D., 1883-1944, who served us faithfully for 30 years as doctor and friend."

Points of View

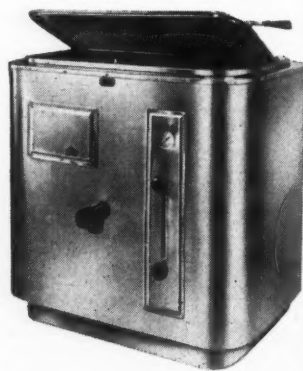
Those who exercise and heat their blood in warm weather should be careful to cool by degrees, and not suddenly; and if they take much cold water, they should put a little spirits with it. There is nothing so good to keep it from injuring you as a glass of good liquor. — *Dr. Beal Downing, 1851.*

* * * * *

Throw all the beer and spirits into the Irish Channel, the English Channel, and the North Sea for a year, and people in England would be infinitely better. It would certainly solve all the problems with which the philanthropists, the physicians, and the politicians have to deal.

—*Sir William Osler.*

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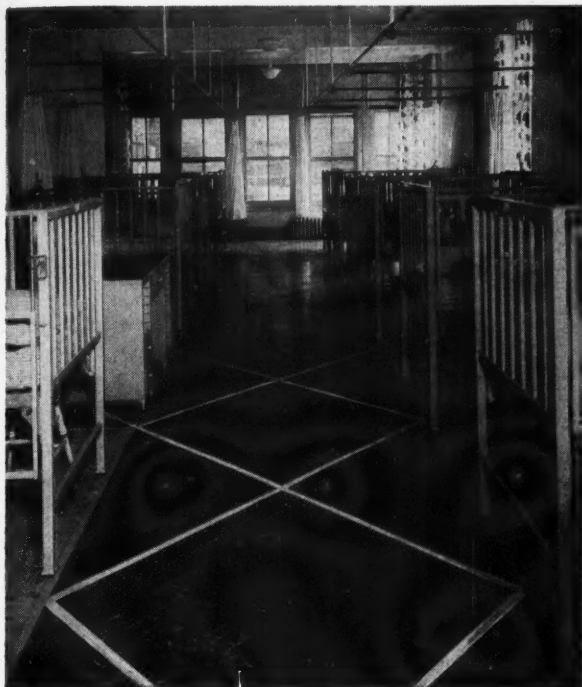
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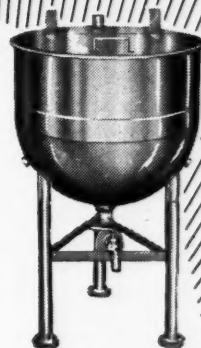
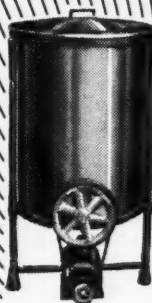
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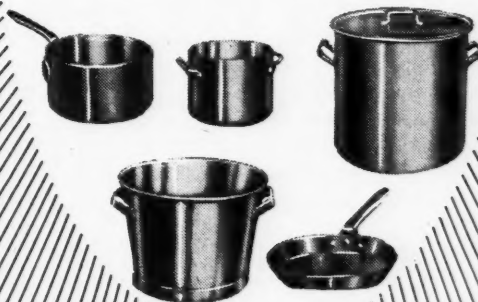
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COPPER & BRASS CO., LIMITED

92 WEST SECOND AVENUE, VANCOUVER B.C.



Book Reviews

(Concluded from page 54)

you are still puzzled about Christmas presents, almost anybody, from 15 to 100, would appreciate a copy of Mrs. Wilson's novel. It is fun-engendering and a genuine contribution to Canadian literature.—J.F.

Medical Education

(Concluded from page 28)

understand better the admirable role of and problems peculiar to smaller local hospitals.

They could envisage more clearly the need to strive for self-reliance and resourcefulness and, in homes of patients, they could not only perceive the expertness of technique but also glimpse the wisdom beyond the knowledge of the veteran in the field.

Refresher Courses

In conclusion, I would refer to another aspect of medical education that is coming rapidly to the fore, i.e., providing refresher courses for the practitioner. The increasing reg-

istration for these courses in our Canadian medical schools is an assurance of their value.

To quote freely from the Queen in *Through the Looking Glass*—it takes all the running he can do for the medical practitioner to keep in the same place, and if he wants to get somewhere else, he must run at least twice as fast as that.

Advances are being made month by month in medical science. These refresher courses afford the practitioner an opportunity to discuss with his fellows and scientific leaders the effects of new discoveries and new techniques on his practice. These courses are usually given in teaching hospitals. I wonder why some of them could not be put on in hospitals situated in other parts of the province so that the practitioners, who would otherwise be unable to attend them, could refurbish their knowledge and their procedures and also keep abreast of new developments.

The writing of these remarks has impressed on me more clearly than ever before the value of the partnership between hospitals and universities in the training of talented and

strong youths for a profession of which it has been truly said: "There is no secular calling that is so philanthropic in its aim, so refining in its influence, and so beneficent in its aspiration as the practice of medicine."

That great Canadian, Sir William Osler, born in a small Ontario village, who might not have been able to give to the world his outstanding talent as a physician if he had been faced with an annual tuition fee of nearly \$500, called it "a ministry of consolation and hope". May our partnership in this cause be mightier yet.

Greek as a Treat

By being so long in the lowest form (at Harrow) I gained an immense advantage over the cleverer boys . . . I got into my bones the essential structure of the ordinary British sentence—which is a noble thing. Naturally I am biased in favour of boys learning English; and then I would let the clever ones learn Latin as an honour, and Greek as a treat.—Winston Churchill.

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118 W. 57TH STREET, NEW YORK, N.Y.
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THIS RAPID TUMBLER DRYER

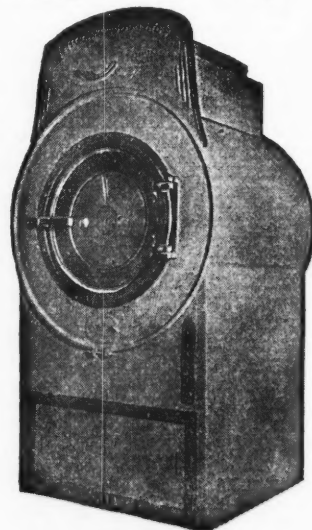
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No. 2 Rapid Tumbler Dryer — capacity 26 pounds of dry clothes in 30 to 45 minutes. Cylinder 36" diameter, 24" deep. Supplied with steam, electric or gas heater.

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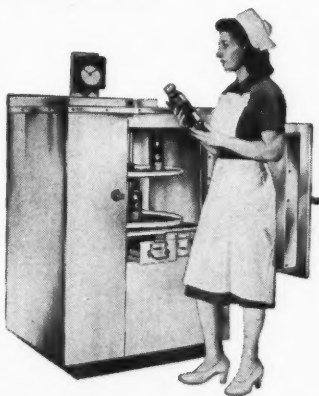
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Highlands and Islands

(Concluded from page 38)

Hospital Region has the Inverness Royal Infirmary as the chief centre for specialized services; from here specialists went out in the Highlands and Island Services though now there is a tendency to make such services more available locally. The Royal Infirmary, by its position in the Northern Kingdom and in the hospital region, would seem to be destined to have a medical school attached to it.

Air Ambulance

Owing to the distances which have to be traversed much depends upon efficient methods of transport. The responsibility rests upon the local authorities. The needs of patients on scattered islands, especially in case of surgical emergency, led to the institution of an air ambulance service. Originally it was provided by an independent corporation which received some subsidy for this work, but that has now been absorbed by British European Airways. The headquarters of the Air Ambulance Service,

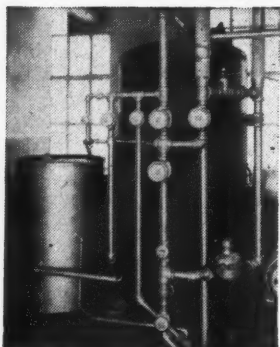
covering the Western Isles as far north as Stornoway, is at Renfrew. Numerous landing places are now available through the establishment of a passenger service, though some of the islands still need to be included for the completion of the scheme. Calls from Shetland, the Orkneys and the north-east are answered by a machine from Aberdeen. During the year 1948, 275 patients were conveyed by aircraft. Emergency work has also been assisted by the extension of wireless and telephonic communication through the aid of grants made to the Highlands and Islands Medical Service.

Although the local authorities retained their responsibility for the domiciliary services in the Highlands and Islands, the central department took an interest in their welfare and were prepared to include them in their scheme of financial assistance. Under the new Act, as in England, some part of the responsibility for tuberculosis patients, which has been a matter of particular concern, passes to the Hospital Regional Boards, as do the general and mental hospitals of the local authorities. The loss of

the co-ordinating activities of the medical officer of health creates a serious defect in the new organization.

The entire Highlands and Islands Medical Services were surveyed in detail by the independent inquiry conducted by P.E.P. (Political and Economic Planning) which reported in 1937. Their conclusion deserves to be quoted as it remains true to the present time. "All authorities are agreed that the setting up of the Highlands and Islands (Medical Services) Fund has been an inestimable boon to the populations concerned. It has vastly improved the medical and nursing services and strengthened the hospital services in the area. The co-ordination of the services of doctors and nurses, the use of modern methods of communication and the tentative development of a centralized hospital scheme are object lessons to other parts of the country. In fact, the scheme has become a model for the development of a health service in a sparsely populated area where communications are extremely difficult." These words remain as a lasting memorial to its value.

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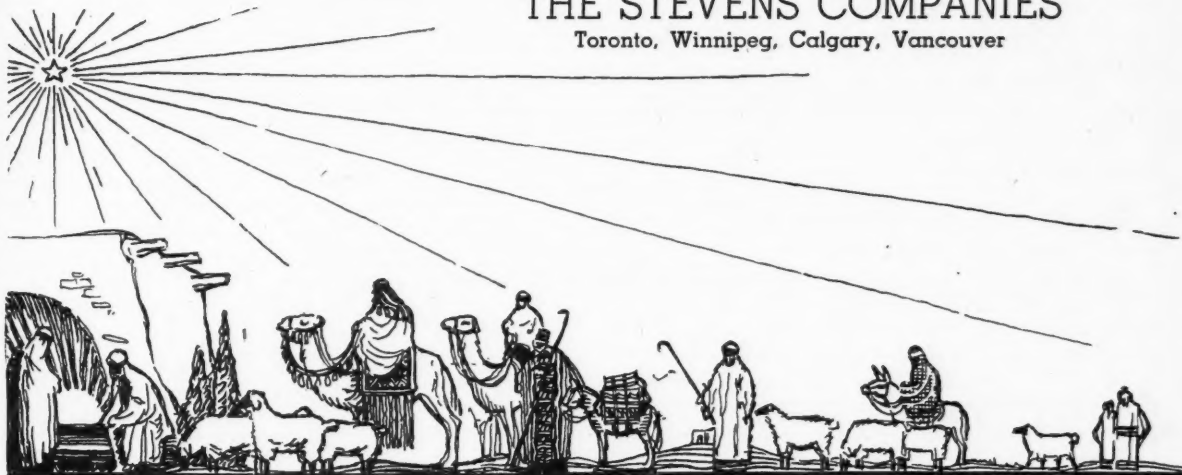
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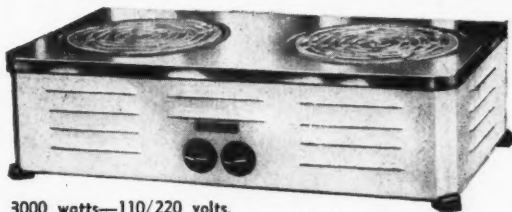
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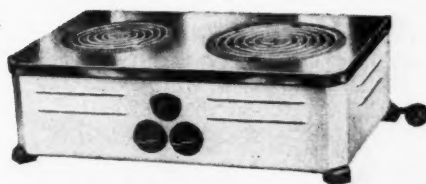


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Provincial Notes

(Concluded from page 58)

of 85, and a paediatric department to care for 58 children are among the services in the new wing.

Nova Scotia

HALIFAX. Elaborate plans for the enlargement of the Victoria General Hospital have been announced. The addition to this new hospital, opened last year, will provide accommodation for between 200 and 250 patients, and space for special departments, e.g., clinical research, neurosurgery, physiotherapy, occupational therapy, and the treatment of cancer and polio.

The hospital also plans to erect a nurses' residence with accommodation for 466 nurses, dietitians, female interns and technicians. The building will be nine storeys high with a penthouse of three additional storeys. The frame is designed to carry four additional floors should further space be required later. There will also be teaching departments for nurses and dietitians, sitting rooms on each floor,

a large reception room on the first floor, and an assembly hall which will seat 400. The architect is C. St. John Wilson of Halifax.

* * * *

HALIFAX. Between \$550,000 and \$600,000 is to be spent to build two new wings for the Children's Hospital. Space is needed for greater bed accommodation, for 4 more operating rooms, and for larger staff quarters.

* * * *

NORTH SYDNEY. A new 150-bed hospital, replacing the Hamilton Memorial Hospital, will be built in the district of Centreville next year, at an estimated cost of \$1,500,000. The new institution is to be called St. Elizabeth's Hospital and will be operated by the Sisters of Charity.

Prince Edward Island

CHARLOTTETOWN. A new addition, which will provide space for 14 beds and a 32-cubicle nursery, is under construction at the Prince Edward Island Hospital. There will be a cov-

ered ambulance entrance, with a two-way drive, at the end of a central corridor. It is planned to enlarge this addition into a 50-bed wing at a later date.

A Formula for Co-operation

The capacity for purposeful and conscious collaboration, assuming an effective satisfactory mode of communication, appears to depend upon three broad essentials: (1) Knowledge based on the experience of effective collaboration, involving techniques ranging from simple group effort, business partnerships, corporate organization and community associations to local, regional, national, and international political systems, all interrelated and interdependent; (2) An attitude of tolerance not merely of opinion but also of diverse positions and interests which call for moderation in competitive and combative efforts; (3) The will to co-operate, which implies an acceptance of fundamental values over-riding personal and group interests or the exigencies of the moment.

—Chester I. Barnard, president, The Rockefeller Foundation.

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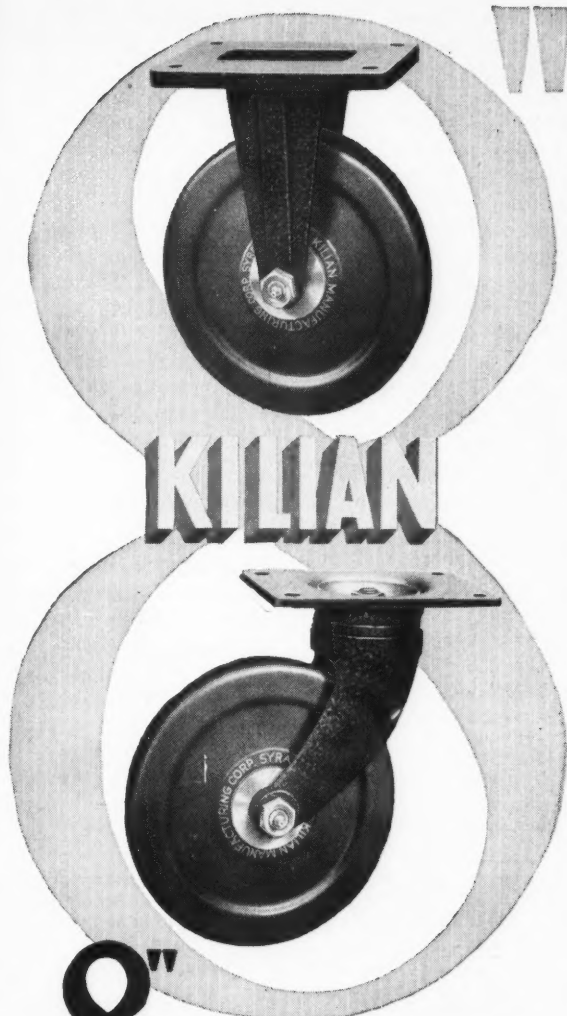


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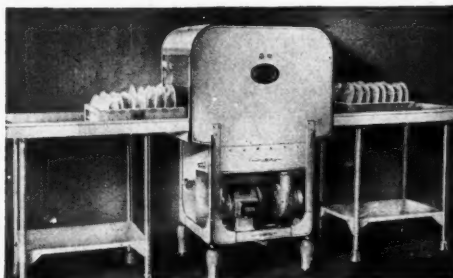
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TORONTO 5

CANADA

Construction Planning

(Continued from page 35)

people at \$30) so that it would soon pay for itself.

The Bedpan Problem

In our planning we should give particular consideration to the work of the nurse. A recent study made in St. Luke's Hospital, Chicago, shows that 50 per cent of the nurse's time is required to handle bedpans, 30 per cent for routine care—bathing, feeding, bed-making, tooth brushing, et cetera—and only 20 per cent for actual nursing treatments. Similar studies made by Pfefferkorn and Roetta confirm these figures. Thus the bedpan is the major nursing problem.

Cleaning a bedpan in an automatic bedpan washer takes a minute; emptying and washing a pan over a toilet bowl, a disagreeable, odorous, messy job, 3 to 4 minutes and is disturbing to the patient. Many nurses prefer to walk 20 to 30 feet to the automatic washer in a bedpan room, rather than to handle the pan in a private toilet. While there are always objections to carrying pans through the corridors

the time and convenience factors usually govern. The bedpan washer and sterilizer, two of which should be strategically located in each nursing unit, costs around \$500 installed; the bedpan toilet and spray for each private room around \$575. If we include the space enclosure, et cetera, each private toilet would cost upward of \$1,000. A small, simple automatic washer which it is hoped can be installed at \$75 to \$100 is still in the design stage and will be a great boon when available.

In my judgment private toilets are not justified for bedpan work, but should be strictly limited to the proportion of the hospital's patients who can afford de-luxe accommodation and to isolation units.

Early ambulation makes it necessary to revise our toilet and bath schedule. Instead of one toilet for 12 beds and one bath for 24, we now require one toilet for 8 and one bath for 16. There should invariably be washing facilities in each patient room.

Hospital specialties always cost more than the standard article. Surgeons' china scrub-up sinks have a

few extra curves but cost \$40 more than an equally practical laundry tray of the same dimensions; the knee control valve, which requires frequent adjustments, costs \$15 more than the simpler elbow valve which many surgeons prefer. The pop-up waste for the lavatory is dirty and always out of order and costs \$2.50 more than the simple chain and plug; the over-size china utility and flushing rim sinks that so often crowd our utility rooms cost \$8 and \$10 more than equally practical smaller fixtures. On the other hand the quiet swirling bowl toilet costs \$3 more than the noisy, gurgling syphon jet but is well worth it.

Electrical Equipment

In electrical equipment the low voltage nurses' signal with rubber covered cord and pear switch costs \$18 a bed while the simple silent mercury toggle switch with pull cord costs but \$7.

In replacement, the rubber cord and switch costs \$10—a new pull cord 10c. Many are advocating the vocal call system between the patient's room and the nurses' station.

(Concluded on page 84)

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SPOT TESTS

SIMPLIFY URINALYSIS

NO TEST TUBES

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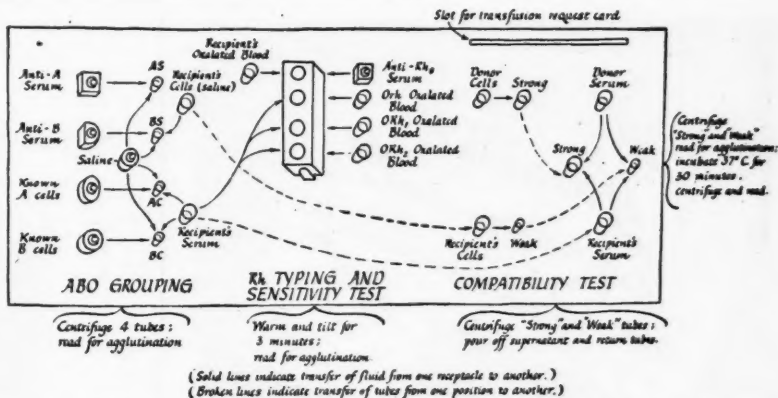
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The Brown Blood Board outfit(1) consists of an etched and stamped metal plate on a hardwood base, with an Rh typing box(2), the necessary reagent bottles and test tubes, and anti-serum bottle adapters which will accommodate any commercial anti-serum bottle.

All routine procedures are indicated on the Board by appropriate labelling in different colors, and by flow lines (see cut). The reagent bottles, tubes and adapters are permanently marked in different colors to match the labelling and coloring of their respective positions in the Board; their sizes or shapes also differ, so that they can fit only in their proper positions. A slot in the Board holds the Donor Card and Transfusion Request Form directly in front of the technician while tests are being made.

Brown Blood Board, complete with Rh typing box, anti-serum bottle adapters, and accessories as follows:

A-2800—Includes 3 each labelled, pipette stoppered bottles for Known A, Known B and saline solution; 3 doz. each labelled test tubes for anti-A, anti-B, Known A, Known B; donor cells, recipient cells; 6 doz. unlabelled test tubes; 1 gross dropping pipettes; 1 doz. four-concavity slides each \$90.00

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Prices in U.S., Canadian prices slightly higher

1. "A Note on Blood Grouping and Cross Matching with Special Reference to a Convenient Grouping Cross Matching Board."—I. W. Brown, Jr., M.D.: In press.

2. "The Demonstration of Anti-Rh Agglutinins—An Accurate and Rapid Slide Test." L. K. Diamond, M.D. and N. M. Abelson, M.D.: J. Lab. & Clin. Med., vol. 30, No. 3, March, 1945.

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Construction Planning

(Concluded from page 82)

These cost \$40 to \$50 a bed and, while they have much to recommend them, they represent a refinement the value of which is yet to be demonstrated.

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These are equipment costs, not including wiring. They will vary in different localities but the comparisons are reasonably accurate.

(To be concluded in January)

Voluntary Workers

(Concluded from page 39)

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I would like to suggest to hospital administrators that they encourage the work of their auxiliaries. Ask them to send representatives to association meetings; tell them the needs of your hospitals, for your auxiliaries are the best supporters you have and they will appreciate being a part of the hospitals they help to support. ●

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(a) a nurse superintendent, and (b) a business manager.
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—Carolyn Wells.

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Have you an opening for a hospital administrator, well qualified by experience and training. Please write Box 522, The Canadian Hospital, 57 Bloor St. West, Toronto 5, for further particulars and personal interview.

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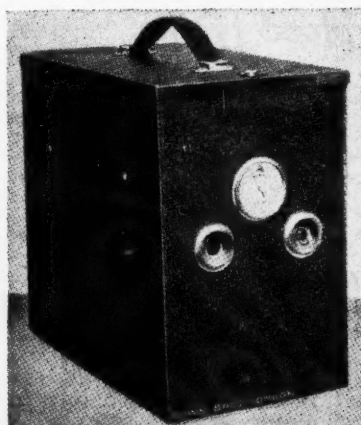
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